NEBRASKA PARTNERS IN PREVENTION

State Incentive Cooperative Agreement (SICA)

REQUEST FOR APPLICATIONS

COMMUNITY STRATEGIES PROGRAM GUIDANCE DOCUMENT

Required Companion Guidance Documents
to this SICA Request for Applications include:

"Evidence-Based Prevention Planning Toolkit" (available now)

and the

"Nebraska Partners in Prevention SICA Guidance Document For Science-Based and Promising Substance Abuse Prevention Strategies" (February 2004 release).

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Section I: Introduction

Nebraska is committed to the health, safety, and development of its children, and to this end is working to reduce underage alcohol, tobacco, and other drug use. In October 2001, Nebraska was awarded funding through a State Incentive Cooperative Agreement (SICA) with the Center for Substance Abuse Prevention (CSAP) of the Substance Abuse and Mental Health Services Administration (SAMHSA), United States Department of Health and Human Services (DHHS). The State will use this funding to advance its agenda by establishing a strong, sustainable system for community-based substance abuse prevention.

The national SICA goals and objectives developed by CSAP for funded SICA states are 1) identification and coordination of federal and state funding and other resources into a comprehensive statewide prevention strategy that will address needed prevention efforts targeted at 12-17 year old youth and their families, eliminate duplication of services in the State, and support evidence-based prevention strategies; and 2) development of a comprehensive state prevention system that will assess substance abuse issues and support and evaluate outcomes of evidence-based strategies to reduce substance abuse issues within the 12-17 age group. Additional information on CSAP, SAMHSA and the SICA Program can be found on CSAP's website: www.samhsa.gov/centers/csap/csap.html.

The goal of the Nebraska SICA Community Strategies Program is to eliminate or significantly reduce substance use in youth ages 12 to 17 by assisting communities to create or expand sustainable, collaborative coalitions that select, implement, and sustain effective substance abuse prevention policies, practices, and programs. The State has adopted the definition of prevention as "the active process of creating conditions and personal attributes that promote the well-being of people,"[1] and, for the purpose of SICA, defines substance abuse as the illegal use of alcohol, tobacco, or other drugs, or any use by minors of alcohol, tobacco, or other drugs, including hazardous chemicals such as inhalants.

Nebraska will support the efforts of community coalitions to develop strong local prevention systems, through which it will fund policies, practices and programs that are locally and culturally appropriate, and which have been proven to be effective in reducing substance abuse. Eligible applicants for this funding are coalitions that include stakeholders from key prevention infrastructures within the community, including, but not limited to, representatives from public health, behavioral health, law enforcement, and education. Coalitions representing Native

[1] Lofquist, William A. 1983. *Discovering the Meaning of Prevention*. Tucson, AZ: AYD Publications.

American tribal communities should include the functional equivalents of these entities. A coalition may apply on behalf of more than one community, offering a multi-strategy application for a combined community approach or submitting separate applications with distinct and different strategies for different communities.

All applicants must conduct two assessments: one of the existing community prevention system infrastructure, and another of the substance abuse problems in their community. All applicants must have gathered locally-valid risk and protective factor data **before** submitting an application. They must provide an assessment of their existing community prevention infrastructure and a plan to develop, enhance, and/or sustain that infrastructure, as well as an assessment of the substance abuse problems in their community and a plan to address their priority substance abuse prevention needs.

This guidance document will offer direction for developing the prerequisites necessary to prepare an application. The Appendices of this guidance document also contain a wealth of information on research-based prevention principles and the risk and protective factor framework for substance abuse prevention that applicants may find helpful in preparing their response.

An "Evidence-Based Prevention Planning Toolkit" has been prepared as an accompaniment to this guidance document. The Toolkit provides a step-by-step guide, with worksheets, for assessing and planning for strong community prevention system infrastructures and effective community substance abuse prevention plans.

A third and final Guidance Document, "Nebraska Partners in Prevention SICA Guidance Document for Science-Based and Promising Substance Abuse Prevention Strategies," will be released in February 2004. In addition to the list of—and criteria for—eligible substance abuse prevention strategies, this document will also contain essential tools and materials for strategy selection and the final steps of the prevention planning process.

Applicants are strongly encouraged to read the guidance document first, and then work through the Toolkit to develop a response to the Request for Applications (RFA). Applications that do not address all of the required elements will be considered non-responsive and will not be reviewed for funding.

Background

Substance abuse-related costs to Nebraska's state government are considerable. According to the National Center on Addiction and Substance Abuse at Columbia University, in 1998 (the last year for which such data are available) the State of Nebraska spent a staggering $291 million—more than 8% of the total state budget—on substance abuse-related costs ranging from treatment to law enforcement to medical and social services.[2] Of that $291 million dollars, the vast majority—nearly $91 dollars out of every $100 State dollars spent on substance abuse-related costs—represents the amount spent on the burdens to public programs. An additional $6 dollars per every $100 dollars spent goes to pay for regulation and compliance activities. Only $3 dollars out of every $100 dollars spent on substance abuse-related costs in Nebraska goes toward actually preventing or treating the problem. This figure of $291 million dollars does not include federal or local governmental spending, or expenses incurred within the private sector, nor does it include the personal devastation that substance abuse wreaks on Nebraska's families, local economies, and environment.

A comparison of national Youth Risk Behavior Survey (YRBS) data with Nebraska YRBS data shows that Nebraska's underage substance using behaviors are higher than the national average in many cases.[3]

Alcohol continues to be the most popular drug among Nebraska youth. According to the 2001 YRBS, Nebraska youth ranked third in the nation in binge drinking, with nearly 40 percent of the State's high school students reporting they had engaged in binge drinking (i.e. five or more drinks in one setting) in the previous 30 days. Nebraska also is well above the national average for the percentage of youth riding with a drinking driver (first in the nation with North Dakota at 43.5% each) and for driving after drinking alcohol (second in the nation at 24.8%). More than one-fourth of Nebraska youth (27.3%) reported having their first drink of alcohol prior to age 13, and 53% of Nebraska youth surveyed reported current alcohol use (sixth in the nation).

Although smoking and the use of smokeless tobacco by Nebraska high school youth has declined since 1997, Nebraska youth still report slightly higher current cigarette (30.5% of all surveyed youth for fifth in the nation) and smokeless tobacco (9.8%) use than their peers in other states. The 2002 statewide SYNAR compliance check program resulted in a noncompliance rate of

[2] "Shoveling Up: The Impact of Substance Abuse on State Budgets." The National Center on Addiction and Substance Abuse at Columbia University. January 2001.
[3] "Morbidity and Mortality Weekly Report: Youth Risk Behavior Surveillance—United States, 2001." U.S. Centers for Disease Control and Prevention.

nearly 20%, meaning that approximately 20% of all retail outlets that sell tobacco products and which were checked for compliance with state laws prohibiting sales of tobacco to minors did indeed illegally sell tobacco products to youth under the age of 18.

The use of illicit drugs is also a substantial issue in Nebraska. In fiscal year (FY) 2001, the percentage of federal sentences in Nebraska that were drug-related (60%) was higher than the national percentage (41%).[4] Among the illicit drugs, marijuana continues to be the most popular among Nebraska youth, with 34.7% reporting having ever used marijuana ("lifetime use"), and 18.5% reporting having used marijuana within the previous 30 days ("current use"). The most alarming trend in illicit drug use, however, is the escalation of methamphetamine use and trafficking. Methamphetamine is readily available throughout Nebraska, and treatment admissions for methamphetamine addictions more than doubled from 1997 to 2001(increasing from 567 to 1,294). While fewer youth reported lifetime use of methamphetamine (5.7%) than marijuana, seizures of methamphetamine in Nebraska—particularly within rural communities—has increased significantly since 1995. According to the U.S. Department of Justice's National Drug Intelligence Center, "The percentage of drug-related federal sentences that were methamphetamine-related in Nebraska in FY2001 was nearly five times the national percentage."

While the data and statistics contained within this section provide a compelling illustration of the critical need for effective substance abuse prevention in Nebraska, this information serves as a backdrop only. Each community presents a unique profile within the statewide portrait. It is the intent of the State, through the State Incentive Cooperative Agreement, to provide the critical support needed for communities and their partner coalitions to build strong local prevention systems that will effectively identify and address priority local substance abuse prevention needs and substantially reduce substance abuse in Nebraska.

Purpose

Research has shown that no single program or strategy can—in and of itself—reduce alcohol and other drug use among youth. The most effective way to tackle this problem is to involve community leaders, schools, teenagers, and their families in coordinated efforts to employ multiple strategies that have demonstrated effectiveness in changing behavior. Nebraska's prevention leadership has analyzed the successes and challenges faced by other states that were previously awarded SICA funds and recognized that before such prevention strategies could be established and expected to thrive, strong prevention infrastructures needed to be established at

[4] "Nebraska Drug Threat Assessment." National Drug Intelligence Center, U.S. Department of Justice. July 2003.

every level. With the award of SICA funding, Nebraska began work to strengthen the prevention system at the State level.

The first step in this process was to develop more active prevention leadership across the State and across agencies. Governor Mike Johanns established a Cooperative Agreement Advisory Council to make legislative and policy recommendations and provide operational advice, and to take other actions appropriate to advancing the State's agenda for prevention, including the coordinated funding of primary prevention strategies for the SICA target population (youth ages 12 to 17). Called Nebraska Partners in Prevention (NePiP), this group represents the Office of the Governor and the diverse stakeholders of the State, and has accordingly culled meaningful State leadership from across organizational boundaries and professional disciplines. NePiP is a 32-member body that is led by the Lieutenant Governor and includes the directors of each major State agency that oversees prevention funding, three State senators, a supreme court justice, and representatives from higher education, the medical and mental health communities, the media, youth, parent/community organizations, and major Nebraska ethnic minority groups. (Appendix L contains a complete NePiP membership list.) NePiP coordinates with other State efforts and has established its own work groups and subcommittees. NePiP will also be responsible for the creation of the Governor's Vision 2010, the State's comprehensive plan to prevent substance abuse.

NePiP has invested time in coming to a consensus on common language, terminology, and practices, and on developing a statewide needs assessment. CSAP requires SICA recipients to provide program- and community-level risk and protective factor data to demonstrate outcomes that show change in both behavioral baseline data and risk and protective factors. Because Nebraska lacked a local-level data collection system for collecting and disseminating this risk and protective factor information, NePiP and its Work Groups initiated a year-long effort that has led to a condensed version of the nationally-validated risk and protective factor student survey so that interested Nebraska communities would have an accessible means for collecting locally-valid risk and protective factor data as required by SICA. Any applicant electing not to participate in this survey must have an alternate means for providing this information and must be able to provide significant and compelling justification for its use as well as documentation of its validity.

The expansiveness of Nebraska is an important consideration when designing a prevention system that will serve the entire State. The rural nature of the majority of Nebraska communities makes the State an ideal venue for conducting community-driven prevention initiatives. Using the funds provided through SICA, NePiP and Nebraska's Office of Mental Health, Substance

Abuse, and Addiction Services (OMHSAAS)—the agency charged by the Governor with administering the SICA initiative—seeks to provide support to a minimum of 25 Nebraska community coalitions. Working in partnership with NePiP, these community coalitions will receive funding, technical assistance, and evaluation services as they put alcohol and other drug abuse prevention research into practice in their communities.

NePiP's primary role over the coming year will be to develop a strategic plan that maximizes the State's substance abuse prevention resources through resource coordination, redirection, and leveraging. This group will continue to lead the development of a coordinated, comprehensive, and effective Nebraska prevention system long after the SICA funding has been disbursed.

The ultimate goal of SICA is not simply to provide money to states to implement effective prevention strategies, but to also build and sustain effective, coordinated prevention systems at the State, regional, and local levels. Once established, these systems will continue to assist communities to use data-driven planning processes to assess local substance abuse needs and to select, implement, and sustain locally appropriate, science-based and promising prevention strategies that will eliminate or significantly reduce substance abuse long after the initial SICA funding cycle is completed.

How Much Money is Available?

A total of $9,000,000 in federal funding—contingent upon continued availability of funding—will be available for the SICA Community Strategies Program, with 85% of that amount to be awarded to subrecipients that will implement science-based and promising substance abuse prevention strategies. A community coalition can apply for a SICA grant in any amount starting at $25,000, but not exceeding $250,000 for each fiscal year. Each fiscal year begins June 1and ends the following May 31st. These funding parameters were established to reflect—and meet the diverse needs of—Nebraska's rural and urban communities. Applicants requesting a level of funding that falls outside these parameters must provide significant and convincing justification for the requested funding amount.

Applicants are expected to present a three-year proposal. However, to receive funding after the initial year, grant recipients must be able to demonstrate substantive progress toward successfully reaching their goals and achieving the outcomes defined by their objectives. Applicants must allocate at least fifty percent of each year's budget for science-based policies, practices, and programs. The remaining funds requested must be targeted to promising strategies—which are defined as those strategies that have been formally evaluated and found to be effective but have

not yet been peer-reviewed. Grant recipients also will be expected to document their ability to continue to achieve and sustain the outcomes targeted in their prevention system and community substance abuse prevention plans after the end of federal funding.

How Many Coalitions Will Be Funded?

SICA funding will be granted to approximately 25 or more community coalitions throughout the State. It is possible for a single coalition to represent more than one community. This could consist of a coalition representing multiple communities with shared plans, or multiple communities with multiple plans. The approach taken is up to the coalition and the communities it represents, and must reflect the needs of each community. In either case, applications should be a collaborative effort across a broad cross-section of community representatives to ensure that the views, perspectives, and needs of all community members are represented.

Who Is Eligible to Apply for Funding?

Eligible applicants are broad-based coalitions applying on behalf of one or more communities. For purposes of this RFA, a community is defined as "an administrative or geographic location defined by legal or administrative boundaries, such as counties, cities, and school districts." A coalition is defined as: "an organized group with strong leadership and multiple partners that has a planning process that is reviewed annually and includes: a community assessment; targeted mission; an action plan with objectives and outcomes; and a process for documentation and feedback."

Coalition membership should be appropriate to each community and should include, but not be limited to, the following entities: public health (e.g., public health departments); behavioral health (e.g., behavioral health regions); law enforcement (e.g., police, county sheriffs, prosecutors); education (e.g., local schools, school districts, Educational Service Units (ESUs)); other infrastructure (e.g., existing coalitions); youth-serving organizations; faith communities; and local units of government. Representatives may include: community leaders, such as the mayor, city council members, chamber of commerce, and/or school board members; clergy and other faith leaders; racial/ethnic leaders; members of voluntary health agencies and other non-profit organizations including hospitals and health care representatives; teachers, youth, parents and families; local college or university representatives; neighborhood associations; and private citizens.

Tribal applicants should include the functional equivalents of these entities. Tribal applicants must be tribal councils or coalitions applying under an approved tribal resolution.

Each coalition must:

1. Provide an assessment of their existing local prevention system infrastructure with an emphasis on leadership, capacity and processes; and provide a plan to develop, enhance, and/or sustain that infrastructure (including addressing missing entities within the coalition membership).

2. Conduct a data-driven assessment of the substance abuse problems in their community and provide an evidence-based plan to address their priority substance abuse prevention issues.

3. Develop a sustainability plan for sustaining prevention outcomes following the grant period.

4. Designate a fiscal agent to receive and account for funding. For purposes of this grant program, a fiscal agent is defined as a unit of local government, a tribal government, or a not-for-profit organization 501(c)3.

5. Provide a budget request that is clearly linked to the goals, objectives, outcomes and services proposed for the budget period, and which represents local investment and planned sustainability.

What Assistance Will NePiP and CSAP Provide During the Application Process?

As part of the competitive application process, NePiP and CSAP—through its Southwest Center for the Application of Prevention Technologies (SWCAPT)—will provide training for coalitions in:

- Community prevention system assessment and planning
- Evidence-based community prevention planning processes.
- Collecting, analyzing and using data to guide decision making
- Selecting science-based and promising substance abuse prevention strategies that are locally and culturally appropriate.
- Evaluation
- Sustainability planning

The intended outcome for coalitions who commit to this training will be the ability to build strong, effective, and sustainable coalitions and local prevention systems that are successful in selecting, implementing and sustaining substance abuse prevention strategies that reduce youth substance abuse throughout Nebraska communities.

The SWCAPT is one of five regionally-based Centers for the Application of Prevention Technologies that serve as CSAP's major national resources supplying technical assistance to support the dissemination and application of substance abuse prevention programs that are scientifically sound and effective at the state and community levels.

How to Apply

Potential interested applicants should fill out and submit the "Potential Applicant Registration Form" provided in Appendix M. Filing this form will ensure that you are placed on all SICA listservs and other notification lists

Applicants will be provided with all required application criteria, as well as training and technical assistance to assist them in building strong prevention systems and effective community prevention plans. All applicants are encouraged to participate in SICA training and technical assistance workshops to receive information on prevention research, prevention strategies, use of needs assessment data, and evaluation design to help in developing their prevention systems and substance abuse prevention plans. A list of these training and technical assistance workshops, including dates and locations, can be found at the official SICA website: www.nebraskaprevention.gov.

Applications for SICA funding must demonstrate:

- A clear definition of the community targeted
- An objective prevention system assessment that clearly identifies strengths as well as areas for development
- A plan for enhancing and/or sustaining that prevention system
- The existence of a committed applicant community coalition that is able to provide leadership, support and organizational capacity
- A sound community assessment that includes analysis of locally-valid risk and protective factor data and clearly indicates priority community substance abuse issues
- A plan for addressing priority substance abuse prevention needs that includes:
    - Clear project goals, objectives and outcomes that are logically linked and that reflect priority community issues

    - The chosen science-based and promising substance abuse prevention strategies are locally and culturally appropriate, and clearly linked to the desired community outcomes.
    - A sustainability plan
    - A process and outcome evaluation plan
- A clear management and staffing plan
- A budget that accurately and realistically reflects the scope of work to be undertaken as well as existing community and coalition support and commitment
- Requested attachments and assurances, including an approved Tribal Resolution from the sovereign Tribal Council for all applicants seeking funding for strategies that will take place on reservation lands.

The deadline to submit an application is April 30, 2004.

How Does the Application Review Process Work?

All applications will be screened by project staff to ensure they are complete. Grant applications that pass the initial screening will be forwarded to the grant selection review panel for scoring. The grant selection review panel, which will be composed of a diverse group of individuals with expertise in substance abuse prevention, community development and SICA initiatives, will make selection recommendations to NePiP. NePiP reserves the right to 1) assign priority points based upon geographic and ethnic distribution in addition to any score given on the content, 2) require applicants to satisfactorily address areas of weakness within the application prior to funding distribution, and 3) to negotiate other areas of the application design, including project budget amounts and line items. Final approval of grants will be made by the Governor.

A list of SubGrant Terms and Assurances is included as Appendix R. Specific reporting requirements for funded subrecipients will be included in the award materials.

When Will the Grants Be Awarded?

Awards will be announced on May 31, 2004.

How Long is the Funding Period?

Applicants are encouraged to submit a three-year proposal, with funding for years two and three contingent upon 1) satisfactory progress toward achievement of identified goals, objectives and outcomes as demonstrated in an annual performance report or continuation application, 2) satisfactory fiscal management, and 3) extension funding approval from CSAP based upon availability of funds. Grant recipients will be required to document efforts to sustain achievement

of their identified substance abuse prevention outcomes beyond the federal funding support period.

What Support, If Any, Will the State, CSAP and CSAP's SWCAPT Provide to Grantees During Implementation?

In addition to funding, SICA grantees will have access to ongoing training and technical assistance, as well as evaluation support secured by the State. Annual prevention conferences and quarterly regional training events will supplement ongoing technical assistance, and the State will foster and support peer interaction and mentoring among communities engaged in similar prevention efforts. Grantees will be required to allocate at least 10% of their budgets for evaluation. The State will retain 5% of the total budget amount granted to secure statewide evaluation services for coalition, community and strategy-level efforts.

Section II: Application Guidance

Application activities under the Nebraska State Incentive Cooperative Agreement (SICA) Request for Applications (RFA) will occur in three phases. Phase One focuses on assessing and building local prevention system infrastructures; Phase Two consists of the initial stages of conducting an evidence-based planning process. Once applicant coalitions have completed their community prevention system assessment and community substance abuse needs assessments in Phase One, then identified priority issues and established goals, objectives and outcomes in Phase Two, the final phase (Phase Three) of the application process will begin—commencing with the release of a companion document listing the science-based strategies that may be selected, as well as criteria for selecting promising prevention strategies.

Why Aren't the Eligible Science-Based Prevention Strategies Included in this RFA?

After examining the outcomes of prevention initiatives conducted by communities in other SICA states, NePiP's membership recognized that a frequent barrier to success occurred when community partnerships or coalitions prematurely selected strategies that ended up being ill-suited to the particular needs of the communities they represented. The end result all too often was that community coalitions struggled to adequately implement and/or sustain their efforts or failed to impact substance abuse problems in their community.

By first learning how to 1) build a strong, supportive local prevention system, 2) conduct an objective community assessment, 3) establish priority community needs, and 4) work through an evidence-based logic model that will guide you in determining what outcomes you want to achieve, your coalition will be more likely to choose strategies that are appropriate to your community's needs, have a greater chance of success, and will be sustainable after SICA funding has ended.

NePiP has developed a number of important tools that will lead you through the first two phases of this RFA process:

- Prevention System Assessment[5] and planning materials, and

[5] The assessment tools are a modified versions of the prevention system assessment tool developed and implemented by James Neal, Pacific Institute for Research and Evaluation, for the South Carolina State Incentive Grant (SIG). NePiP additionally acknowledges the extensive work of Mike Lowther, former Director of CSAP's Southwest Center for the Application of Prevention Technologies, and current CSAP Director of the Division of State and Community Systems Development, from whose extensive work in prevention system development these materials are heavily indebted.

- the Evidence-Based Prevention Planning Toolkit[6].

The third and final Guidance Document, "Nebraska Partners in Prevention SICA Guidance Document For Science-Based and Promising Substance Abuse Prevention Strategies," to be released in February, 2004, will lead you through the third and final phase of selecting locally and culturally appropriate evidence based substance abuse prevention strategies. In addition to the list of—and criteria for—eligible substance abuse prevention strategies, this document will also contain essential tools and materials for strategy selection and the final steps of the prevention planning process. The companion document listing the eligible science-based strategies and criteria for selecting promising prevention strategies will be released in February 2004. A compendium of general prevention principles is included as Appendix I.

Phase One: Prevention System Assessment

Nebraska's prevention leadership determined early on that attempts to bring science to practice weren't likely to be effective or sustainable if a concurrent effort was not made at the outset to build strong local prevention infrastructures to support those efforts, now and in the future. Accordingly, the decision was made that eligible applicants for SICA funding must be coalitions whose membership included local prevention system infrastructure partners—such as public and behavioral health departments, educational institutions, and law enforcement officials—in order to ensure that applicant coalitions have the breadth and depth of leadership and commitment of community resources needed to succeed.

In Phase One of the application process, you will assess your current prevention system infrastructure and construct a plan to strengthen and build that infrastructure.

Using the Prevention System assessment and planning matrices, worksheets and Logic Models that accompany this guidance document (Appendix B), applicant coalitions will be able to analyze the indicators for systems change for a number of core qualities in three specific areas (leadership; capacity; and process) and then develop a plan for strengthening their local prevention system.

The purpose of the assessment is to identify strengths as well as priority areas for continued growth and development. The Prevention System Assessment tool uses a "Gap Analysis" to help

[6] NePiP gratefully acknowledges the efforts of Karen Abrams of the Southwest Center for the Application of Prevention Technologies who authored this Toolkit in collaboration with the Nebraska HHS Office of Mental Health, Substance Abuse, and Addiction Services.

coalitions prioritize areas for development by measuring the discrepancies—or "gaps"—between their current stage of development for a number of indicators and the stage of development they feel is needed to be most effective.

Here's an example:

As an applicant, one of the indicators you will rate concerns strategic planning by the prevention system's leadership. It reads:

> *"Prevention is identified as a priority program area and funded accordingly in the budgets of the prevention system member organizations and agencies."*

It may be that this statement is not at all true of your local prevention system at this time. On a scale of 1 to 10, you rate this statement a "1" because coalition members strongly disagree that it is representative of your local prevention system as it currently exists. But coalition members give that same statement a priority rating of "9," because they consider raising the indicator rating to be a high priority for the local prevention system in order for it to be successful at achieving its goals, objectives and outcomes. Subtracting your assessment rating (1) from your priority rating (9) illustrates the gap between where your local prevention system is today and where coalition members feel it needs to be in order to maximize its effectiveness. These gaps are areas of future development for your local prevention system. In prioritizing which gaps—or areas of development—to address in your prevention system development plan, your coalition should not only look at the largest gaps, but also analyze which of those gaps your local prevention system has the ability and capacity to address at this point in time.

Applicant coalitions will use this tool to rate a number of indicator statements for the following core qualities and system change areas:

Coalition Leadership

- Vision
- Conceptual clarity
- Political will
- Inclusion
- Strategic planning
- Accountability

Coalition Capacity

- Structural organization
- Knowledge, skills, and abilities
- Funding and other resources
- Cultural competency
- Sustainability

Coalition Processes

- Collaboration and communication
- Operating procedures and protocols
- Evidence-based planning and prevention practices
- Training and technical assistance
- Monitoring and evaluation
- Sustainability
- Marketing/recognition
- Accountability

The gap analysis that results from this exercise will illustrate important areas of systems change for each coalition. **Please note: applicants <u>will not</u> be penalized for being under-developed in any of the assessed areas, but rather will be scored on the quality and objectivity of their analysis, and the quality and objectivity of their plan to develop and strengthen their local prevention system.** All applicants must work through this process to provide an assessment of their current infrastructure and a development plan for strengthening that infrastructure in the areas in which the coalition members determine it is underdeveloped.

The steps outlined in the Prevention System Planning Logic Model and Example Logic Model included in Appendix B demonstrate the process for constructing a Prevention System development plan. These documents summarize the steps contained in the Evidence-Based Prevention Planning Toolkit that serves as a companion document to this RFA. The Toolkit provides in-depth guidance for utilizing a logic model process to develop a prevention system plan to address areas of underdevelopment. An additional worksheet, the "Allies Matrix," is also included in this RFA as Appendix C. This Allies Matrix is an adaptation of a worksheet developed by the Praxis Project to help coalitions and community groups strategically identify key stakeholders and opinion leaders to include in their effort.

Phase Two: Community Substance Abuse Prevention Plan

In addition to building a strong local prevention system, developing a comprehensive, evidence-based community substance abuse prevention plan is vital for the success of any prevention initiative. The Evidence-Based Prevention Planning Toolkit that accompanies this RFA is provided to assist community coalitions in conducting effective planning processes that will result in high-quality applications. The Toolkit breaks the planning process into small sequential steps and leads users through each step with the aid of work sheets, helpful hints, and examples. In Phases Two and Three of the SICA RFA process, applicant coalitions will work through the Toolkit to create their community substance abuse prevention plan.

The prevention planning process includes the following steps:

- **Mission**
- **Assessment**
- **Target Population**
- **Problem Statement**
- **Goals**
- **Objectives**
- **Outcomes**
- **Strategies and Activities**
- **Implementation Plan**
- **Evaluation**
- **Sustainability Plan**

These progressive series of steps will help you to develop prevention strategies from the ground up. While prevention planning is often more of a circular process than a linear one, going through the steps as laid out in this document and accompanying Toolkit is the best way to build a prevention plan that has all the necessary pieces in place to succeed. These steps are described in detail beginning on page 26 of this document.

Phase Three: Strategy Selection, Implementation and Sustainability

Phase Three of the application process—choosing strategies and activities, developing an implementation and evaluation plan, and designing a system to sustain prevention initiatives and outcomes—will take place after communities have developed their prevention system plans and developed their community prevention goals, objectives and outcomes. **Please Note: the list of eligible science-based strategies, as well as criteria for eligible promising prevention strategies, will be released in February 2004 in the final required Guidance Document for this Request For Applications: "Nebraska Partners in Prevention SICA Guidance Document For Science-Based and Promising Substance Abuse Prevention Strategies."** In addition to the list of—and criteria for—eligible substance abuse prevention strategies, this document will also contain essential tools and materials for strategy selection and the final steps of the prevention planning process.

Regional community technical assistance workshops and Training of Trainers will be held on the various stages of substance abuse prevention planning through March 2004. For dates, times and locations of these trainings, please refer to the official Nebraska Partners in Prevention SICA website at: www.nebraskaprevention.gov.

Section III: Application Format and Content

Application Format

Applications must be typewritten on 8.5-inch x 11-inch paper. All narrative sections are to be completed using a 12-point font with at least 1-inch margins. Tables, figures, or maps may use a smaller font size. Paragraphs must be double-spaced. All pages should be numbered sequentially, including the cover page and any maps, charts, tables, attachments, and appendices. Page limits for narrative sections are noted in pages 23-30. Any narrative sections exceeding these limits will not be reviewed. Attachments must be limited to those specifically requested in the application instruction. No other attachments will be accepted or reviewed (e.g. annual reports, brochures).

Bidders must submit one (1) original and (12) copies of the application. Photocopies or exact computer-generated replicas are acceptable. Applications should not be bound and should be printed on white paper.

The closing date for the receipt of all applications will be 4:00pm on April 30, 2004. Applications may be mailed, sent Federal Express, or hand delivered.

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West Prospector & Folsom Streets
Lincoln, NE 68522

Bidders should allow sufficient time for delivery by the U.S. Post Office, remembering that mail delivery from outlying areas can take several days. Only applications **received** by 4:00 P.M. on April 30, 2004, will be considered on time and eligible for funding. Any application received after this time will not be reviewed and will be returned to the applicant. **No exceptions.**

Content: Bidders should organize their application as follows:

I. Application Cover Sheet

II. Application Checklist

III. Abstract (max. of one page)

IV. Coalition Mission, Description and Organizational Capacity (max. of two pages)

V. Coalition Prevention System Plan (max. of 10 pages)

a. Assessment
b. Problem Statement
c. Goals
d. Objectives
e. Outcomes
f. Strategies
g. Activities
h. Implementation Plan
i. Evaluation

VI. Community Substance Abuse Prevention Plan (max. of 15 pages)

a. Assessment
b. Problem Statement
c. Target Population
d. Goals
e. Objectives
f. Outcomes
g. Strategies
h. Activities
i. Implementation Plan
j. Sustainability Plan
k. Evaluation

VII. Management/Staffing Plan (max. of 2 pages)

VIII. Budget and Budget Justification

IX. Statements of Commitment

X. Certifications

I. Application Cover Sheet

(See Appendix N)

II. Application Checklist

The application checklist (Appendix O) should be included as the second page of your application. The checklist indicates your application's contents, in order, and will facilitate the evaluation of your application.

III. Abstract (maximum of one page)

Provide a brief, one page summary of your coalition's:

- proposed substance abuse prevention system plan that describes the system as it currently exists, as well as plans to develop and sustain the system; and
- proposed community substance abuse prevention plan.

The abstract should identify your coalition, the substance abuse problem in your community, your target population, and your proposed solutions, including goals, strategies, and predicted outcomes.

IV. Coalition Mission, Description and Organizational Capacity (maximum of two pages)

First, your coalition will develop a mission statement associated with this project—one or two sentences that express the reason member organizations have come together to jointly conduct substance abuse prevention planning. Describe the common purpose for coming together, what the coalition plans to do to achieve this purpose, and any principles or beliefs guiding the initiative. A clear mission statement will help steer your coalition through the remainder of the planning process. If the coalition is applying on behalf of multiple communities, this mission statement should encompass the substance abuse prevention planning missions of the participant communities.

Second, describe the coalition, the geographic area(s) and population(s) served and the commitments coalition members have made to the coalition. State how long the coalition has been in existence, and describe its structure and leadership. Provide a list of coalition members, and describe the specific role each member has played and will play in the prevention system and community substance abuse prevention assessment and planning processes. Describe current collaborative efforts with other agencies and/or community groups serving the identified target population(s). Describe how the proposed strategies will be coordinated, and how they fit into the existing substance abuse and violence prevention strategies provided by other organizations

and agencies. Describe youth and community input into strategy development and/or implementation.

Finally, describe the organizational structure of the coalition. Identify the coalition's fiscal agent, and describe its experience in managing funds. Describe in detail the capacities of your coalition to adapt to changes and to fruitfully engage the entire community in the substance abuse prevention planning initiative. You should also address the methods you have used and will use to ensure cultural competency and inclusion.

V. Prevention System Assessment and Plan (maximum of 10 pages, excluding the Logic Model Attachment)

Assessment

The Prevention System Assessment should include a detailed description of the overarching local prevention system that reflects the geographic reach of the applicant coalition. This assessment should address current strengths as well as areas of development for the core prevention system qualities of leadership, capacity and process, as well as the systems change areas listed on pages 17-18 of this document. The purpose of the assessment is to identify strengths as well as priority areas for continued growth and development. The Prevention System Assessment matrix, along with optional worksheets, is included in Appendix B of this document. In addition to the indicators listed on the matrix for the core qualities of leadership, capacity and process, include an analysis of contextual conditions and other factors impacting the prevention system. See the Evidence-Based Prevention Planning Toolkit for a description of contextual conditions.

Areas of Development (a.k.a. "Problem Statement")

Once an assessment of the prevention system is complete, priority issues for systems change and development should be identified using the "Gap Analysis" described on pages 16-18 of this document. The priority areas should be described in this section, and any underlying issues that either help strengthen or are hindering the growth and development of the prevention system should be explained.

Goals

Describe the long-term changes you would like to see in the priority areas you identified. These are your prevention system goals.

Objectives

Describe the changes that will have to take place in order to reach your goals. These changes must be related to the underlying issues that either help strengthen or are hindering the growth and development of the prevention system.

Outcomes

Describe the measurable outcomes – the specific degree of change you expect to see, within a finite period of time – that will indicate that systems change and development has occurred.

Strategies

Describe the overall method or methods (e.g. strategies, activities, policies) you will use to achieve the prevention system outcomes you have identified, and explain how your choices are locally and culturally appropriate.

Activities and Implementation Plan

Describe the specific actions that you will take, every step of the way, in order to successfully implement your chosen strategies. Include a time line and identify key responsibilities.

Evaluation

Describe how you will measure and analyze progress toward achieving the prevention system growth and development outcomes described in your prevention system plan. The evaluation plan narrative should include a description of how baseline and outcome data for key indicators will be collected, and describe how progress toward outcomes will be monitored and evaluated for 1) continuous improvement, and 2) to determine whether project objectives and outcomes are being achieved. Describe how the coalition will monitor activities and measure progress toward attaining outcomes during the project year, including both the implementation plan for systems growth and development (process evaluation), as well as successes in achieving desired outcomes (outcome evaluation).

CSAP's SICA Program requires that both States and their subrecipients participate in collecting, analyzing and disseminating process, outcome and other related evaluation data. Potential subrecipients are encouraged to use CSAP's core measures in their program level evaluations. A list of these core measures can be found in Appendix G.

Note: Be sure to include a copy of your Prevention System Logic Modal as an attachment to your application. A Logic Model template and example are included in Appendix B.

VI. Community Substance Abuse Prevention Plan (maximum of 15 pages, excluding the Logic Model attachment)

If you submit a single application that includes a multi-community approach with distinctly different strategies for each community, then each community represented should develop its own comprehensive prevention plan. Your application should include a separate description of each community's plan.

Assessment

A detailed needs and resources assessment must be included, with a clear definition and description of the community(ies) to be served by the project that defines the geographic boundaries and the population. The assessment should include community demographics, local risk and protective factors, substance abuse incidence and prevalence, and other related problem behaviors.

To begin the planning process, you will need to know what the primary substance abuse-related problems are that are affecting your community's health and well-being; who is affected by these issues as well as the extent to which they are affected; and where the greatest need is. This will require gathering what is known as baseline data—data that describe the status of substance abuse in your community as it is at the time your prevention planning is initiated. Only by knowing how things looked when you started will you know if your initiative has effected any significant changes later on.

Demographic and social indicator data; risk and protective factor data; and rate, prevalence, and incidence data are necessary for identifying a community's substance abuse problem and providing evidence of its underlying causes. These kinds of data can be obtained from student surveys (such as the Nebraska Risk and Protective Factor Student Survey) as well as law enforcement and judicial systems, schools, social services, or other records, surveys, and focus groups. More information on risk and protective factors in prevention planning can be found in Appendix F. A compendium of social indicator and archival data sources is included as Appendix D. Don't forget to include an analysis of contextual conditions as part of your assessment process, taking into consideration the social norms of the community, the availability of alcohol and other drugs, and the level of enforcement of existing laws and policies.

In addition to gathering data on community needs, you will want to identify resources—both the level of current community engagement in prevention (so you do not duplicate services) as well as the potential human, financial, and in-kind resources that might be available to help develop and implement your coalition's prevention plan. Include an analysis and accounting of amounts

and sources of existing funding streams and other resources that are already supporting substance abuse prevention efforts within the community.

Problem Statement

Briefly summarize the most important substance abuse issues compromising the health and well-being of the community. Using your community assessment data, define the problem your planning initiative will address, stating this in terms of the problem behaviors, knowledge, or attitudes that currently exist and which need to be changed.

Target Population

Of course, any prevention initiative is only effective if it is properly targeted. Based on your needs and resources assessment, you should already have a good idea of the population of 12 to 17 year old youth on which you would like to focus. Your target population may include individuals; groups of individuals who are connected by relationships; groups of individuals who are connected geographically; or individuals within systems, like schools or courts. Describe the population your initiative is targeting, including the approximate number of youth to be reached and the risks they face with regard to alcohol and other drug use. Include information about the geographic area to be served, as well as cultural, socio-economic, age and educational characteristics of the target population to be served. State whether your strategies will be focused at a universal (all youth), selected (specific groups of youth) or indicated (high-risk youth) population. (For more information on this Institutes of Medicine classification system, see Appendix F).

Goals

Define your community's substance abuse prevention goals. These goals identify in broad terms how your initiative is going to change things in order to solve the problem you have identified, and should describe the kind of long-term changes you want to see occur. In order to sufficiently focus your efforts, it's best to limit yourself to three goals or less.

Objectives

Objectives generally address the underlying conditions (e.g. environmental conditions, risk and protective factors) that either contribute to, or protect against, substance use. Objectives describe the kinds of changes in those underlying conditions that will have to take place in order to reach your goals. These underlying issues are usually related to knowledge, attitudes or behavior. Develop at least two objectives for every goal.

Outcomes

Outcomes are written statements that provide specific information about exactly what tangible accomplishments are expected as a result of the initiative. Outcomes describe the measurable outcomes – the specific degree of change you expect to see, within a finite period of time – that will indicate that attitudes, knowledge or behavior has changed within your target population. Develop at least one outcome for every objective.

Strategies and Activities

You will select strategies from an approved list of science-based and promising strategies that will be released in February 2004. Strategies are the overall methods (e.g. policies, practices and programs) you will use to achieve your prevention outcomes. Activities are the specific steps you will take, every step of the way, as part of an overall strategy. A comprehensive prevention plan should include environmental as well as individually-based strategies. (More information about the use of environmental strategies and risk and protective factors in prevention planning can be found in Appendix F.) Describe the theory that underlies each strategy you select. Illustrate how the strategies and activities you choose will result in the desired outcomes. Describe how the proposed strategies are 1) culturally competent and linguistically and developmentally appropriate. Document that all strategies are either new strategies or significant and substantial expansions and/or enhancements of existing strategies. Develop short- and intermediate-term measures (outcome indicators) that indicate your initiative is on its way to achieving desired outcomes. If the project includes efforts with parents or supportive adults, explain how strategies directed at those populations will be linked to the substance abuse prevention efforts involving youth.

Your prevention plan must document the allocation of at least 50 percent of the funding for science-based substance abuse prevention strategies, with the remainder allocated for promising substance abuse prevention strategies. If you are a coalition applying on behalf of multiple communities, you must ensure that at least 50% of funding for communities, overall, is budgeted to science-based strategies. (This will be discussed further in the February release of the SICA eligible funding list. See the Glossary, Appendix J, for clear definitions of science-based and promising strategies as required by this application.)

Implementation Plan

An implementation plan is the series of activities that you've developed – laid out in chronological order – that need to take place in order for your prevention plan to move forward. Your implementation plan should describe the order of the activities you intend to accomplish

and the resulting measurable outputs you will track for each activity. Specify target dates for prevention planning and/or implementation benchmarks and assign organizational or staff responsibility for each of these benchmarks. You can write out your timeline in narrative form, but charting activities on a calendar is recommended. Implementation worksheets are provided in the Evidence-Based Prevention Planning Toolkit. A sample Implementation Work Sheet is included as Appendix E.

Evaluation Plan

CSAP's SICA Program requires that both States and their subrecipients participate in collecting, analyzing and disseminating process, outcome and other related evaluation data. Evaluation is the process of analyzing whether or not you are on track for achieving your outcomes, and why or why not. It is important to plan the evaluation before you implement your initiative. Your evaluation should include both program or strategy-level outcome measures that will assist you in analyzing the issues related to your initiative's accomplishments (i.e. outcome evaluation), as well as a process evaluation dealing with how your project operates (e.g., administration, organizational structure, staff training and background, monitoring system, intensity and duration of services provided, cost of services, and budget).

As with the prevention system evaluation, be sure to describe how the project will be monitored and evaluated for 1) continuous improvement, and 2) to determine whether project objectives and outcomes are being achieved. Clearly describe how you will monitor activities and measure progress toward attaining outcomes during the project year. In addition, explain how you will collect and track short-term, intermediate and long-term outcome indicator data (e.g. risk and protective factors, social indicator, archival data). Describe which of CSAP's core measures will be included in program level evaluations. (A list of these core measures can be found in Appendix G.) Describe how continuous improvement will be achieved. In addition to your local evaluation efforts, the State will provide additional evaluation support as part of the statewide SICA initiative.

Applicants must allocate at least 10% of the overall requested funding for evaluation. Of that amount, 5% will be withheld by the State to obtain statewide evaluation services of all grantees.

Note: You must include in your application assurances that you will 1) participate in the 2005 biennial Nebraska Risk and Protective Factor Student Survey or utilize a similarly validated method for obtaining data on youth access to substances and community risk and protective factor s that is compatible with—and comparable against—the data collected for

your baseline assessment, and 2) comply with all state and national evaluation efforts and requirements.

Sustainability Plan

Sustainability is the process of maintaining and sustaining the outcomes of your initiative into the future. Sustainable substance abuse prevention efforts create an infrastructure that supports and maintains the prevention planning process and builds the capacity of the community to continue engaging in substance abuse prevention planning and implementation. Your sustainability plan should include the process of change and improvement that your project will go through when you make modifications based on the findings of your process and outcome evaluations. It should also include your plans to secure human resources, financial support, and in-kind support to ensure that your initiative is able to continue to achieve its targeted outcomes after the original funding period is over. Finally, it should also include the efforts of your coalition and community to adapt to changes in substance abuse prevention systems at the State, regional and local levels, and any subsequent modifications in your community's planning that might be necessary to achieve successful outcomes. Your sustainability plan should specifically address (1) prevention systems; (2) resources; (3) partnerships and collaboration; and (4) continued development of the prevention workforce, and (5) future outcomes.

Note: Be sure to include a copy of your Community Substance Abuse Prevention Planning Logic Modal as an attachment to your application. A Logic Model template and example (assessment through outcome selection) are included in Appendix H. The second half of the Community Substance Abuse Prevention Planning Logic Model (strategy selection through sustainability planning) will be included in the final Guidance Document, "Nebraska Partners in Prevention SICA Guidance Document for Science-Based and Promising Substance Abuse Prevention Strategies," which will be released in February 2004.

VII. Management/Staffing Plan [maximum of two pages, excluding resumes]

Your staffing plan should describe your project staff, qualifications, responsibilities, and time devoted to the project. Be sure to describe how the staff composition reflects the racial and ethnic characteristics of the target population, and how it meets any special language needs your target population may have. Staff resumes should be included (two-page limit per resume).

VIII. Budget and Budget Justification

Applicants must prepare a Project Budget Summary, as well as a Detailed Project Budget: Revenue and Expenses using the format provided in Appendix P. The budget request must be

clearly linked to the goals, objectives, outcomes and services proposed for the budget period **June 1, 2003 – May 31, 2004.** Your budget should detail expenditures for personal services, employee benefits, travel, operating expenses, supplies, professional services, administrative costs, and any other relevant expenditures. At least 50% of the funds requested must be allocated toward the implementation of science-based strategies as described in the companion document listing the science-based strategies that may be selected, with the remaining funds allocated toward promising prevention strategies that meet the criteria established in the same document. At least ten percent of the budget must be allocated for evaluation, with the State retaining five percent of the total budgeted amount to secure statewide evaluation services of coalition, community and strategy-level interventions. Grantees may also include in their budgets appropriate funding to secure necessary Internet capability if it is not already available (grantees will be required to file reports electronically via the Internet).

Grantees will be required to attend annual 2-3 day conferences in Lincoln as well as regional training and technical assistance workshops on a quarterly basis, and should budget to cover those costs accordingly. Funds may not be used for capitol construction.

In addition, applicants must also complete a Budget Justification which provides supportive description and justification for each line item; describes the applicant's ability to leverage structural and financial resources at the community and private sector levels; describes the applicant's ability to track, manage and administer federal grant funds; documents that at least 50% of the budget is allocated to science-based strategies; documents that at least 10% of the overall budget is allocated for evaluation; and describes plans for sustaining the program beyond the grant period. (A focus of grant review will be sustainability of outcomes, and so grantees must provide evidence of community support and ownership, indicating any expenses that will be covered by in-kind matching.)

A line item for any subcontractor must be included. Applicants should name the subcontractor, describe the services to be performed, and provide a breakdown of and justification of the proposed costs. Any costs included in the indirect cost rate cannot be listed under "other direct costs." The negotiated indirect cost agreement must be submitted with required documentation if the indirect cost rate is included as a budget line item.

Note: no funds may be used to supplant existing funds or maintain existing activities, and all strategies must be either new strategies or substantial enhancements and/or expansions of existing strategies. Likewise, coalition members may not use funding to underwrite or supplant existing and/or typically expected strategies or services. For example, Regional

Prevention Centers are funded by the State to provide substance abuse-related training and technical assistance to community members and community coalitions. Any SICA funds allocated to Regional Prevention Centers—or other coalition partners—must be used for new or significant and substantial expansions of services not otherwise available or expected. NePiP reserves the right to limit and/or negotiate specific budget requests and line items with grantees.

IX. Statements of Commitment

Organizations committed to participating as members of the coalition should provide statements of commitment with the following information:

- Name, address, and telephone number of committing organization
- Which sector the organization represents:
    - Public Health
    - Behavioral Health
    - Law Enforcement
    - Education
    - Other (Specify)
- The organization's previous involvement in the coalition
- The organization's previous involvement in substance abuse prevention
- The nature of the commitment and resources to be provided by the organization as a participating member of the coalition

X. Attachments

Attachments must be limited to those specifically requested in the application instruction (e.g. completed Prevention System and Community Substance Abuse Prevention Planning Logic Models). No other attachments will be accepted or reviewed (e.g. annual reports, brochures). **Note:** applicants requesting funding for strategies that will occur on reservation lands must include an approved Tribal Resolution from the sovereign Tribal Council.

XI. Certifications

See Appendix Q

Section IV: Application Scoring

The maximum points to be awarded for each application section for Phases I through III follows:

APPLICATION COMPONENT		POTENTIAL SCORE
Abstract		**Required**
Coalition Description		**20**
Mission Statement	5	
Description	5	
Organizational Capacity	10	
Prevention System Plan		**60**
Assessment	15	
Key Development Areas	15	
Goals and Objectives	10	
Outcomes	10	
Strategies and Activities	10	
Community Prevention Plan		**90**
Assessment	15	
Issue Identification	10	
Target Population	5	
Goals and Objectives	10	
Outcomes	15	
Strategies and Activities	10	
Local Evaluation Plan	10	
Sustainability Plan	15	
Implementation Plan		**30**
Management/Staffing Plan	10	
Monitoring and Continuous Improvement	10	
Budget and Budget Justification	10	
TOTAL		**200**

NOTE: In addition to the above—in order to ensure equitable distribution of funding across the state—NePiP reserves the right to award priority points based on geographic and/or ethnic considerations.

APPENDIX A

SICA PHASING AND TIME LINE

PHASES OF SICA APPLICATION PLANNING AND PREPARATION

PHASE ONE: DECEMBER 2003 ONGOING

PREVENTION SYSTEM ASSESSMENT AND DEVELOPMENT

PHASE TWO: DECEMBER 2003 THROUGH FEBRUARY 2004

COMMUNITY PREVENTION SYSTEM PLANNING, FIRST STEPS:

- Assessment
- Problem Identification
- Target Population Identification
- Goals
- Objectives
- Outcomes

PHASE THREE: FEBRUARY 2004 THROUGH APRIL 2004

COMMUNITY PREVENTION SYSTEM PLANNING, FINAL STEPS:

- Strategy and Activity Selection
- Outcome Indicators, Outputs and Process Indicators
- Implementation Planning
- evaluation Planning
- Sustainability Planning

SICA APPLICATION PLANNING AND PREPARATION TIMELINE

DECEMBER 8, 2003: Request For Applications (RFA) and "Evidence-Based Prevention Planning Toolkit" Released

FEBRUARY 2004: Final SICA Guidance Document, "Nebraska Partners in Prevention SICA Guidance Document for Science-Based and Promising Substance Abuse Prevention Strategies," released.

APRIL 30, 2004: SICA Applications due to the State of Nebraska

MAY 31, 2004: SICA Funding Awards are announced

JUNE 1, 2004: SICA implementation begins

APPENDIX B

PREVENTION SYSTEM ASSESSMENT

The following pages in this appendix provide a prevention system assessment tool, as well as work sheets to assist you and your coalition to conduct an effective and useful prevention system assessment and planning process:

- Prevention System Assessment Matrix for Leadership, page 36
- Prevention System Assessment Matrix for Capacity, page 37
- Prevention System Assessment Matrix for Process, page 38
- Assessment Worksheets (to record justification for scores), pages 39-45
- Summary Sheet for Priority Areas of Development, page 46
- Logic Model for Prevention System Planning, page 47
- Logic Model Examples for Prevention System Planning, pages 48-49

The assessment tools used in the Nebraska SICA application process are a modified version of the prevention system assessment tool originally developed and implemented by James Neal, Pacific Institute for Research and Evaluation, for the South Carolina State Incentive Grant.

Ongoing training and technical assistance is available and coordinated through the State's SICA training and technical assistance system. Information on trainings and technical assistance in your area, as well information on how to obtain additional training and technical assistance, can be found at the official SICA website: www.nebraskaprevention.gov

Core Quality *and* Systems Change Areas		Indicators	Assessment Score Strongly Disagree ◄——► Strongly Agree	Effectiveness Score Strongly Disagree ◄——► Strongly Agree	Gap (Priority Score *minus* Assessment Score)
LEADERSHIP	Vision	The prevention system is guided by written vision and mission statements that have been developed and adopted by its members.	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	
		Prevention system members believe they are collectively capable of making a difference.	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	
	Conceptual Clarity	There is consensus on a definition of substance abuse that guides all the participating agencies and organizations.	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	
		Prevention system members share a common understanding and use of evidence-based substance abuse prevention.	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	
	Political Will	The organizations and agencies that make up the prevention system influence and motivate each other and the rest of the community to accomplish mutually agreed upon prevention goals.	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	
		The organizations and agencies that make up the prevention system have the political will to create positive community change.	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	
		The prevention system has secured the support and investment of key stakeholders and opinion leaders.	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	
		The prevention system and its membership is proactive in developing, supporting and modeling public and other policies that reinforce substance abuse prevention goals.	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	
		The prevention system is successful in raising awareness about prevention issues within the community.	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	
	Inclusion	Leadership of the prevention system reflects the demographics of the communities served	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	
		Prevention system members model cultural diversity and inclusion within their own agencies and organizations.	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	
		Leadership among prevention system members is a shared responsibility.	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	
		The prevention system cultivates and develops new leadership on an ongoing basis.	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	
		There are open channels of communication and interaction between the prevention system and the community	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	
		All agencies and organizations whose mission includes prevention are represented in the prevention system.	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	
	Strategic Planning	Prevention is identified as a priority program area and funded accordingly in the budgets of the prevention system member organizations and agencies.	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	
		Prevention system members work collaboratively with each other and other prevention stakeholders to develop a comprehensive substance abuse prevention plan that guides substance abuse prevention decisions for the community	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	
		Prevention system members base decision making on carefully collected and analyzed data.	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	
		The strategies implemented through the prevention system are comprehensive in scope, and include both environmental and individual strategies.	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	
	Accounta-bility	Prevention system actions are guided by the collective needs of the community rather than the individual needs of its members	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	
		The prevention system reports its activities, use of resources, and outcomes to the community on a regular and ongoing basis.	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	

Core Quality *and Systems Change Areas*		**Indicators**	**Assessment Score** Strongly Disagree ◄► Strongly Agree	**Effectiveness Score** Strongly Disagree ◄► Strongly Agree	**Gap** (Priority Score *minus* Assessment Score)
Capacity	Organizational Structure	There is a designated department for substance abuse prevention within key community agencies and prevention system members.	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	
		The prevention system and its member organizations and agencies have the capacity to allocate and manage financial and other (e.g. in-kind, volunteer, etc) prevention resources.	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	
		The prevention system receives tangible support (funding, resources, staffing, other in-kind, etc.) from its members.	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	
	Knowledge, Skills and Ability	Prevention system members have knowledge of resources that provide information on evidence-based prevention strategies that are scientifically proven to be effective.	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	
		Members of the prevention system have the necessary knowledge, skills and ability to use data from the community as the basis for prevention planning and decision-making.	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	
		Members of the prevention system have the necessary knowledge, skills and ability to use a logical, sequential, data-driven process for prevention planning and for selecting, implementing and evaluating prevention strategies.	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	
		Prevention system members are knowledgeable about the risk and protective factors that affect youth substance abuse in their community.	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	
		Prevention system members have the knowledge, skills and abilities necessary to effectively use a combination of strategies to change the physical, social, legal and/or economic environment, as well as to change the behavior of individuals.	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	
		Members of the prevention system have the necessary knowledge, skills and ability to use formal evaluation to help achieve desired substance abuse prevention goals.	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	
		Prevention system members have the necessary skills and abilities to effectively share their prevention knowledge with others.	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	
	Funding and Other Resources	The prevention system is able to leverage funds and other resources are from multiple sources in order to support priority prevention initiatives.	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	
		Prevention system members commit their own resources toward the collective action of the system	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	
		Funding streams are “braided” or coordinated across prevention system member agencies and organizations in order to maximize coordination and impact of prevention strategies on desired outcomes.	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	
		Prevention system members are aware of—and are maximizing—all of the prevention funding streams that are available to the areas or region(s) they serve.	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	
		The prevention system and its member organizations and agencies are able to successfully acquire and leverage financial and other (e.g. in-kind, volunteer, etc) prevention resources to address prevention priorities.	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	
	Cultural Competency	Prevention system members are able to meet national standards for culturally competent and linguistically appropriate services.	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	
		Prevention system members ensure that all prevention strategies implemented or funded are culturally appropriate.	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	
	Sustainability	The prevention system has developed a written plan to achieve sustainable outcomes over time	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	
		The prevention system is able to acquire and allocate resources to sustain key prevention initiatives.	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	

Core Quality *and* Systems Change Areas		Indicators	Assessment Score (Strongly Disagree ↔ Strongly Agree)	Effectiveness Score (Strongly Disagree ↔ Strongly Agree)	Gap (Priority Score *minus* Assessment Score)
Process	Collaboration and Communication	Prevention system members collaborate to achieve prevention priorities.	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	
		There are processes and channels of communication among prevention system members to routinely share new prevention technology and other information.	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	
		Prevention system members share their data and databases.	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	
	Operating Procedures and Protocols	Prevention system members have a mutually agreed upon process for conflict resolution.	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	
		Prevention system members have a mutually agreed upon process for decision-making.	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	
		Prevention system meetings are scheduled on a routine basis.	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	
		Records of the outcomes of prevention system meetings are maintained and disseminated to all invested groups.	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	
	Evidence Based Planning and Prevention Practices	Agency and organizational prevention service delivery practices among the prevention system members reflect evidence-based strategies such as the use of a risk and protective factor framework.	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	
		Prevention system members consider evidence-based approaches (both environmental and individual) as the first option when selecting and implementing prevention strategies.	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	
		Prevention system members use environmental strategies to change social norms in the community through policies and practices.	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	
		Prevention system members select outcome measures that are logical, achievable, and based on a shared approach that reflects lessons learned from research.	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	
	Training and Technical Assistance	Prevention trainings and/or orientations are mandatory for new employees of prevention system member organizations.	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	
		Training on substance abuse prevention is routinely supported, promoted, and made available to prevention providers.	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	
		There is a process for securing and delivering technical assistance to community and school-based prevention providers.	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	
		Members and staff of the prevention system's member organizations and agencies have adequate access to training and technical assistance, including information on evidence-based strategies, to enable them to work effectively in the community.	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	
		Prevention system members use state and/or national prevention training and technical assistance resources.	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	
	Monitoring and Evaluation	Prevention system members use ongoing monitoring and continuous improvement to achieve desired prevention outcomes.	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	
		The lessons learned from evaluation are used to improve the performance of substance abuse prevention strategies.	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	
	Sustainability	Prevention system members have a mutually agreed upon process, driven by the needs of the community, for identifying which prevention initiatives should be sustained.	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	
		Prevention system members dedicate meeting time to identify and monitor measures for maintaining sustainability.	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	
		Prevention system members create written sustainability plans for key prevention efforts.	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	
	Marketing / Recognition	Prevention system members consistently share prevention successes with one another, stakeholders, and key decision-makers at all levels.	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	
	Accountability	There is a system for identifying overlaps in prevention services in order to minimize duplication.	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	
		Evidence-based planning, policies and practices guide decisions of policy, funding, technical support and training by all prevention system members.	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	
		Contract and grant procedures used by prevention system members reflect objective analysis of data and evidence-based practices in prevention program planning and implementation.	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	
		Guidelines for funding or re-granting of funds that are issued by prevention system members for prevention strategies are reviewed by other members prior to release.	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	
		Prevention system members routinely and collectively review proposals for funding.	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	

These worksheets may be used, if you wish, to capture your coalition's discussion on the indicators for each systems change area. The relevant points of this discussion can then be used in creating your coalition's prevention system plan.

Core Quality ***and Systems Change Areas***		***NOTES: Reasons for GAP Scores***
LEADERSHIP	**Vision**	
	Conceptual Clarity	
	Political Will	

Core Quality ***and Systems Change Areas***		***NOTES: Reasons for GAP Scores***
LEADERSHIP	**Inclusion**	
	Strategic Planning	
	Accounta-bility	

Core Quality ***and Systems Change Areas***		***NOTES: Reasons for GAP Scores***
CAPACITY	**Organiza-tional Structure**	
	Knowledge Skills and Abilities	

Core Quality ***and Systems Change Areas***		***NOTES: Reasons for GAP Score***
CAPACITY	**Funding and Other Resources**	
	Cultural Compe-tency	
	Sustainability	

Core Quality *and Systems Change Areas*		*NOTES: Reasons behind GAP Score*
PROCESS	**Collabora tion and Communi-cation**	
	Operating Procedures and Protocols	
	Evidence Based Planning and Prevention Practices	

Core Quality *and Systems Change Areas*		*NOTES: Reasons for GAP Score*
PROCESS	**Training and Technical Assistance**	
	Monitoring and Evaluation	
	Sustainability	

Core Quality *and Systems Change Areas*		*NOTES: Reasons for GAP Score*
PROCESS	**Marketing and Recognition**	
	Accountability	

If you find it useful, this worksheet can be used to 1) summarize on one sheet the systems change areas and indicator s you found to be priority development areas for your prevention system , and 2) describe related desired outcomes that will build or strengthen your prevention system.

PREVENTION SYSTEMS ASSESSMENT SUMMARY SHEET – PRIORITY AREAS OF DEVELOPMENT

CORE QUALITY	SYSTEMS CHANGE AREA	INDICATOR	CURRENT GAP SCORE	DESIRED OUTCOMES
Leadership				
Capacity				
Process				

SICA Phase One: Logic Model for Prevention System Planning

Step One	**Step Two:**	**Step Three:**	**Step Four:**	**Step Five:**	**Step Six:**	**Step Seven**	**Step Eight:**	**Step Nine:**	**Step Ten:**
Mission Statement	Prevention system assessment	Identify key areas for development	Define your goals	Identify objectives	Define measurable outcomes	Select strategies and activities to achieve outcomes	Develop an implementation plan and outputs	Develop an evaluation plan	Develop a sustainability plan
Question: Does the prevention system have an established and mutually agreed upon mission statement that is current and relevant?	**Question:** What are the strengths as well as areas of development for the prevention system?	**Question:** Where are the priority gaps, starting with leadership, then capacity and then process?	**Question:** What are the long-term changes in the prevention system change areas and indicators that you need to make in order to enhance the effectiveness and sustainability of your prevention system?	**Question:** What underlying issues must be changed in order to accomplish your goals?	**Question:** How will you quantify the achievement of your goal(s)?	**Question:** What are likely to be the most effective methods for achieving your outcomes?	**Question:** What is the chronological order of the activities that need to occur; how will you measure outputs; what are key target dates and benchmarks; and who is responsible for each step?	**Question:** How will you monitor and continuously improve your efforts to achieve your goal(s)?	**Question:** How will you ensure that desired outcomes are sustained?
Action: 1. If there is not an established and mutually agreed upon mission that is current and relevant, develop one 2. Clearly and concisely express the purpose of the prevention system planning effort to your stakeholders and the public	**Action:** 1. Describe contextual conditions 2. Identify community substance abuse prevention stakeholders and collaborators 3. Collect, assess and analyze baseline data (e.g. the Prevention System Assessment and other documentation)	**Action:** 1. Use the "Gap Analysis" to prioritize systems change areas and indicators for development	**Action:** 1. Express the ultimate accomplishment(s) you want to achieve within your prevention system—this is your picture of the future 2. Focus on the prevention systems change areas and indicators that are the highest priority	**Action:** 1. Make a direct, logical link between the goals and objectives you have defined 2. Make your objectives specific and measurable 3. Address the underlying conditions (e.g. indicator and its causes) that contribute to the gap scores you have identified	**Action:** 1. Identify outcomes, and where necessary, outcome indicators 2. Outcomes should be specific, measurable, and time limited	**Action:** 1. Identify effective strategies, then select activities that will be necessary to achieve the strategies	**Action:** 1. Create a timeline table that describes the chronological order of activities that need to occur; key dates and benchmarks; and who is responsible for each step 2. Identify outputs for each activity	**Action:** 1. Establish a process for monitoring and measuring progress towards prevention system goals 2. Be sure to include both process and outcome measures	**Action:** 1. Identify strategies that will ensure that desired outcomes are maintained and sustained

EXAMPLE LOGIC MODEL FOR PREVENTION SYSTEM PLANNING, STEPS ONE THROUGH EIGHT

STEP ONE **Mission** Statement	STEP TWO: Prevention system **assessment**	STEP THREE: Identify **key areas** for development	STEP FOUR: Define your **goals**	STEP FIVE: Identify **objectives**	STEP SIX: Define measurable **outcomes**	STEP SEVEN Select **strategies and activities** to achieve outcomes	STEP EIGHT: Develop an **implementation plan** and **outputs**
Example: To work collaboratively as a prevention system to ensure long-term reductions in substance abuse related problems in order to improve the health and wellbeing of our community.	*Instructions:* • Describe **contextual conditions** • Identify community substance abuse prevention **stakeholders** and **collaborators** • Collect, assess and analyze baseline data (e.g. the **Prevention System Assessment** and other documentation)	*Example:* Leadership **Priority Gap**: All agencies and organizations whose mission includes prevention are *not* represented in the prevention system.	*Example:* **Goal:** To increase the active involvement of individuals, agencies and organizations invested in substance abuse prevention in the work of the prevention system.	*Example:* **Objective**: **1.** To increase the active involvement of key stakeholders within education in the work of the prevention system. **2.** To increase the active involvement of key stakeholders within law enforcement in the work of the prevention system.	*Example:* **Outcomes:** **1.** Key stakeholders within law enforcement will be actively involved in the work of the prevention system by June 30, 2005. **2.** Key stakeholders within education will be actively involved in the work of the prevention system by June 30, 2005.	*Example:* **Strategies and Activities:** **1.** Develop a plan to attract the active involvement of key stakeholders within (1) law enforcement and (2) education. • Complete the "Allies Matrix" and use the information to develop a specific approach to engage the interest and attract the active involvement of (1) law enforcement and (2) education • Meet with Chief of Police • Meet with School Superintendent and Principal **2.** Formalize relationships between the prevention system and (1) law enforcement and (2) education. • Generate a memorandum of understanding (MOU) to increase the enforcement of underage drinking. • Develop a subcommittee to provide input and advice to the local Safe and Drug Free Schools coordinator.	*Instructions:* • Create a timeline table that describes the chronological order of activities that need to occur; key dates and benchmarks; and who is responsible for each step. • Identify **outputs** for each activity *Example Outputs:* **Outputs:** • Completed "Allies Matrix" • Lists of specific ideas to engage the interest of key stakeholders. • Record of – and notes from – meeting with Chief of Police. • Record of – and notes from – meeting with School Superintendent and Principals. • MOU between prevention system and local law enforcement. • Minutes from meetings of Safe and Drug Free Schools (SDFS) subcommittee of prevention system. • SDFS plan.

EXAMPLE, CONT'D. LOGIC MODEL FOR PREVENTION SYSTEM PLANNING, STEPS ONE THROUGH EIGHT

STEP ONE **Mission** Statement	STEP TWO: Prevention system **assessment**	STEP THREE: Identify **key areas** for development	STEP FOUR: Define your **goals**	STEP FIVE: Identify **objectives**	STEP SIX: Define measurable **outcomes**	STEP SEVEN Select **strategies and activities** to achieve outcomes	STEP EIGHT: Develop an **implementation plan** and **outputs**
Example: To work collaboratively as a prevention system to ensure long-term reductions in substance abuse related problems in order to improve the health and wellbeing of our community.	*Instructions:* • Describe **contextual conditions** • Identify community substance abuse prevention **stakeholders** and **collaborators** • Collect, assess and analyze baseline data (e.g. the **Prevention System Assessment** and other documentation)	*Examples:* Capacity **Priority Gap**: Prevention system members are *not currently* able to meet national standards for culturally competent and linguistically appropriate services.	*Example:* **Goal:** To increase the cultural competence of prevention system members and staff.	*Example:* **Objective:** To increase the prevention system's compliance with national standards for culturally competent and linguistically appropriate services.	*Example:* **Outcomes:** By June 30, 2007, 100% of the individuals, organizations and agencies that make up the local prevention system will meet national standards for culturally competent and linguistically appropriate services (33% by June 30, 2005; 66% by June 30, 2006).	*Example:* **Strategies and Activities:** Adopt the national Culturally and Linguistically Appropriate Standards (CLAS). • Train all individuals working within the prevention system on the CLAS standards. • Encourage interagency adoption of a policy to make training on the CLAS standards a requirement for all new hires within the first 3 months of employment.	*Instructions:* • Create a timeline table that describes the chronological order of activities that need to occur; key dates and benchmarks; and who is responsible for each step. • Identify **outputs** for each activity *Example:* **Outputs:** • Schedule of trainings on CLAS standards. • Develop a training protocol for new hires.
		Example: Process **Priority Gap**: There is *no process in place* for identifying overlaps in prevention services in order to minimize duplication.	*Example:* **Goal:** To increase the effectiveness of the prevention system's stewardship of community prevention resources.	*Example:* **Objective:** To reduce duplication in prevention services.	*Example:* **Outcome:** By June 30, 2007, the duplication of prevention services will be reduced by 35% (20% by June 30, 2005; 30% by June 30, 2006).	*Example:* **Strategies and Activities:** Develop ways to reduce duplication in prevention services. • Undertake a prevention service-mapping project that identifies: (1) what kinds of prevention services are available, (2) where in the community they are available, (3) what target populations are served, and (4) where duplications in services exist. • Incorporate analysis of map into the comprehensive community substance abuse prevention (SAP) plan. • Act on analysis through implementation of SAP plan.	*Example:* **Outputs:** • Prevention service map illustrating types and locations of prevention services, target populations served and existing duplications.

APPENDIX C

THE "ALLIES MATRIX"[7]

Brainstorm a list of potential allies who care about your issue and might be willing to take some action. Allies can be formal organizations with staff, volunteer organizations, church groups, non-profits, community organizing groups that work with diverse communities of color, or individuals. However, do not identify a category of people unless there is a viable way of developing a relationship with them. After you have developed your initial list of allies, place their name in the first column of the table below. Then analyze and answer the questions in each column for each potential ally. This will help you develop a strategy to enlist their support and/or collaboration.

Organization or person whose mission/ vision includes prevention	Do you have an existing relationship?	What are their prevention mandates (if any)?	What are their prevention goals?	What are their resources?	What are their needs?	How does collaborating within a prevention system benefit them?	What's their "market share"? (e.g., credibility, influence, reach)	Other

[7] The "Allies Matrix" is adapted from a work sheet developed by the Praxis Project, a project of the Tobacco Technical Assistance Consortium that is funded by Robert Woods Johnson, The American Legacy Foundation, and the American Cancer Society. This worksheet is included in the Praxis Project's "Fighting Back on Budget Cuts; A Toolkit," which can be found online at: www.thepraxisproject.org/toolkit/index.html.

APPENDIX D

SOCIAL INDICATOR MEASURES OF RISK FACTORS AND RELATED ADOLESCENT PROBLEM BEHAVIORS[8]

Risk Factor and Associated Measures	Operational Definition
COMMUNITY DOMAIN	
Availability of Drugs	
Alcohol Sales Outlets	Number of retail alcohol sales outlets per 100,000 population
Alcohol Net Sales	Net Sales of ABC outlets per 100,000 population
Tobacco Sales Outlets	Estimate of average yearly number of retail tobacco sales outlets per 100,000 population
Transition and Mobility	
New Home Construction	Number of new building permits issues for single and multi-family dwellings per 1,000 population
Households in Rental Properties	Percentage of all households living in rental housing
Net Migration	Number of new residents who moved into an area minus number of residents who moved out per 1,000 population
Low Neighborhood Attachment	
Population Voting in Elections	Reported as the percentage of the population registered to vote who vote in the November elections
Prisoners in State and Local Correctional Systems	Number of new admissions to State and local prisons, by the committing court per 100,000 population
Extreme Economic Deprivation	
Unemployment	Percentage of labor force not employed
Free and Reduced Lunch Program	Percentage of students in public schools (K-12) whose applications have been approved for FRLP
Temporary Assistance for Needy Families	Number of persons participating in the federal TANF program per 1,000 population
Food Stamp Recipients	Average monthly number of food stamp participants per 1,000 population
Adults Without High School Diploma	Percentage of total population, age 25 and older, who report the following level of educational attainment: Grades 9-12, no diploma
Single Parent Family Households	Percentage of family households with spouse absent

[8] These social indicators were selected and validated by the CSAP Six-State Consortium based upon their predictive ability and availability. This data is intended to be used as supplemental information in addition to that collected by risk and protective factor student surveys. These forms can be accessed at the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services website at www.dmhmrsas.state.va.us/Organ/CO/Offices/OSAS/Prevention/SocialIndicatorsDef/pdf

Risk Factor And Associated Measures	Operational Definition
FAMILY DOMAIN	
Family History of Problem Behavior	
Adults in Alcohol or Drug Treatment Programs	Unduplicated number of adults in State-support AOD treatment programs per 1,000 population
Chronic Liver Disease	Number of deaths attributed to liver disease and cirrhosis of the liver per 100,000
Family Management Problems	
Children Living Away From Parents	Number of children (age 0-17) living in home situations other than with one or both parents or guardians per 1,000 children (age 0-17)
Children Living in Foster Care	Average daily rate of children (age 0-17) in State-supervised, family-based foster care per 1,000 children (age 0-17)
Runaways	Number of runaway arrests (age 0-17) per 1,000 juveniles (age 0-17)
Child Abuse Cases	Number of reports alleging child abuse and neglect (age 0-17) per 1,000 juveniles (age 0-17)

Risk Factor and Associated Measures	Operational Definition
SCHOOL DOMAIN	
Low Commitment to School	
Event Dropouts	Percentage of students (grades 9-12) who drop out of school in a single year
Status Dropouts	Percentage of adolescents (age 16-19) who have not completed high school and are not enrolled in school, regardless of when they dropped out

Risk Factor and Associated Measures	Operational Definition
INDIVIDUAL DOMAIN	
Early Initiation of Problem Behavior	
Dropouts prior to 9th grade	Number of students (grades 7-8) who drop out of school prior to 9th grade, per 1,000 students (grades 7-8)
Vandalism Arrests ages 10-14	Number of adolescents (age 10-14) arrested for vandalism (including residence, non-residence, vehicle venerated objects, police cars or other) per 1,000 adolescents (age 10-14)
Alcohol-related arrests (10-14)	Number of adolescents (age 10-14) arrested for alcohol violations (DUI, public drunkenness, liquor law violations), per 1,000 adolescents (age 10-14)
Personal and property crime arrests (10-14)	Number of adolescents (age 10-14) arrested for personal crimes (criminal homicide, aggravated assault, robbery, ,rape) and property crimes (burglary, larceny theft, arson, motor vehicle theft) per 1,000 adolescents (age 10-14)

Risk Factor and Associated Measures	Operational Definition
PROBLEM BEHAVIOR-OUTCOMES	
Substance Use	
Juvenile alcohol-related arrests	Number of juvenile arrests (age 10-17) for alcohol violations (DUI, public drunkenness, liquor law violations), per 100,000 adolescents (age 10-17)
Juvenile drug-related arrests	Number of juvenile arrests (age 10-17) for drug violations (possession, sale, use, growing, and manufacturing of illegal drugs), per 100,000 juveniles (age 10-17)
Adult alcohol-related arrests	Number of adult arrests (age 18 or older) for alcohol violations (DUI, public drunkenness, liquor law violations), per 100,000 adults (age 18 or older)
Adult drug-related arrests	Number of adult arrests (age 18 or older) for drug violations (possession, sale, use, growing, and manufacturing of illegal drugs), per 100,000 adults (age 18 or older)
Adult drunken driving arrests	Number of adult arrests (age 18 or older) for DUI of DWI per 1,000 adults (age 18 or older)
Alcohol-related traffic fatalities	Percentage of all traffic fatalities related to alcohol
Alcohol-related traffic crashes	Percentage of all traffic crashes related to alcohol
Drug Use during pregnancy – ATOD treatment	Number of pregnant women receiving ATOD treatment from State-supported treatment centers, per 1,000 live births
Drug use during pregnancy – birth records	Number of pregnant women using alcohol, tobacco, or other drugs while pregnant, per 1,000 live births
Violence	
Juvenile arrests for violent crimes	Number of juvenile arrests (age 10-17) for violent crimes (murder, aggravated assault, robbery, rape), per 100,000 juveniles (age 10-17)
Adult arrests for violent crimes	Number of adult arrests (age 18 or older) for violent crimes (murder, aggravated assault, robbery, rape), per 100,000 adults (age 18 or older)
Homicides	Number of homicide victims per 100,000 population
Non-Violent Crime	
Juvenile arrests for curfew, vandalism and disorderly conduct	Number of juvenile arrests (age 10-17) for curfew, vandalism, and disorderly conduct per 100,000 juveniles (age 10-17)
Juvenile arrests for property crimes	Number of juvenile arrests (age 10-17) for property crimes (burglary, larceny, arson, motor vehicle theft), per 100,000 juveniles (age 10-17)
Adult arrests for property crimes	Number of adult arrests (age 18 or older) for property crimes (burglary, larceny, arson, motor vehicle theft), per 100,000 adults (age 18 or older)
Suicide	
Adolescent suicide	Number of successful suicides by juveniles (age 10-17) per 1,000 juveniles (age 10-17
Adolescent Sexual Behavior	
Adolescent pregnancies	Number of pregnancies to adolescent females (age 10-17) per 1,000 female adolescents (age 10-17)
Birthrate among juveniles	Number of live births to female adolescents (age 10-17) per 1,000 adolescent females (age 10-17)

APPENDIX E

IMPLEMENTATION PLAN WORK SHEET

Coalition/Community:_____ **Page____ of _____**

Goal:_____

OBJECTIVE(S)	OUTCOME(S)	STRATEGIES AND ACTIVITIES	TIME LINE (IMPLEMENTATION PLAN) START / END DATE	RESPONSIBLE STAFF	EVALUATION PLAN

APPENDIX F

UNDERSTANDING RESEARCH-BASED SUBSTANCE ABUSE PREVENTION

Throughout this process, you will read and hear repeatedly of the importance of instituting evidence- or science-based policies, practices, and programs that have been validated through research. This section will help ground you in what is meant by evidence- and science-based prevention, and will provide guidance as to how to decrease substance abuse in your community by bringing prevention research to practice.

Using Science and Research-Based Prevention to Help Communities Reduce Alcohol, Other Drug Use and Related Problems among Young People

After more than two decades, researchers have been able to identify which prevention strategies are and are not effective in preventing substance abuse. Prevention strategies that work are those that decrease risk factors while increasing protective factors, or directly impact use of alcohol, tobacco and other drug problems. Therefore, to choose effective strategies, communities receiving SICA funding must first gather locally-valid risk and protective factor data and include an analysis of that data in their substance abuse prevention planning process. Generally speaking, no single strategy can effectively reduce or eliminate substance abuse in a community, so an effective and comprehensive community substance abuse prevention plan will identify a number of specific strategies to use in a variety of settings with multiple target groups.

What Are Risk and Protective Factors?

Risk factors are those conditions or situations that increase the likelihood that a child will develop one or more health and/or behavior problems in adolescence, such as substance abuse and violence. Protective factors are the conditions or situations that decrease the likelihood of future behavior problems such as substance abuse and/or violence. Risk and protective factors exist at each of the four domains of youth interaction: 1) individual/peer; 2) family; 3) school; and 4) community.

In order to assist local communities to develop a risk and protective factor profile that uniquely reflects their community, NePiP has contracted for the development and implementation of a statewide risk and protective factor student survey that will be implemented in October 2003 and conducted every other year after that. Interested schools and communities will be able to participate in the Nebraska Risk and

Protective Factor Student Survey (NRPFSS) and receive an individualized survey report at no cost under the sponsorship of NePiP.

Although the original risk and protective factor framework, as originally developed by Hawkins and Catalano, contains a number of risk factors and protective factors, the Nebraska Risk and Protective Factor Student Survey focuses on those risk and protective factors that are 1) highly correlated to substance abuse, 2) actionable at the local level, and 3) cannot be readily measured by any means other than a student survey. These risk and protective factors, by domain, are as follows:

DOMAIN	HIGHLY CORRELATED RISK FACTORS COLLECTED BY THE NRPFS SURVEY	HIGHLY CORRELATED RISK FACTORS AVAILABLE THROUGH OTHER SOCIAL INDICATOR OR ARCHIVAL DATA MEANS	RISK FACTORS NOT ACTIONABLE OR EASILY ACTIONABLE AT THE COMMUNITY LEVEL
Individual/Peer	▪ Early initiation of the problem behavior* ▪ Favorable attitudes toward the problem behavior (including perception of risk and of peer use)* ▪ Friends who engage in a problem behavior (perception of peer use) ▪ Alienation and rebelliousness		▪ Constitutional factors
Family	▪ Family management problems ▪ Favorable parental attitudes and involvement in the problem behavior*	▪ Family conflict	▪ Family history of the problem behavior*
School	▪ Early and persistent antisocial behavior ▪ Lack of commitment to school*	▪ Academic failure beginning in elementary school	
Community	▪ Availability of drugs, alcohol and firearms* ▪ Community laws and norms favorable toward drug use, firearms and crime* ▪ Low neighborhood attachment and community disorganization	▪ Transitions and mobility ▪ Extreme economic deprivation	▪ Media portrayals of violence ▪ Extreme economic deprivation

Note: * Indicates those risk factors with the highest correlations to substance abuse

The core protective factors that have been identified as most influential in preventing youth substance abuse are:

- Healthy behaviors
- Healthy beliefs and clear standards
- Bonding (attachment/commitment)
  - Opportunities for bonding
  - Skills for bonding
  - Recognition of bonding
- Individual characteristics

The key actionable protective factors that were validated by Hawkins' and Catalano's research relate to *bonding*. To build bonding, three conditions must be present: **opportunities**, **skills** and **recognition**. According to Hawkins' and Catalano's research:

> "Positive bonding makes up for many other disadvantages caused by other risk factors or environmental characteristics. Children who are attached to positive families, friends, school, and community, and who are committed to achieving the goals valued by these groups are less likely to develop problems in adolescence. Studies of successful children who live in high-risk neighborhoods or situations indicate that strong bonds with a caregiver can keep children from getting in trouble.
>
> Children must be provided with **opportunities** to contribute to their community, family, peers and school. The challenge is to provide children with meaningful opportunities that help them feel responsible and significant.
>
> Children must be taught the **skills** necessary to effectively take advantage of the opportunity they are provided. If they don't have the necessary skills to be successful, they experience frustration and/or failure. Children must also be **recognized** and acknowledged for their efforts. This gives them the incentive to contribute and reinforces their skillful performance."[9]

What Do You Do Once You've Identified Your Community's Risk and Protective Factors?

Once your coalition has gathered local-level causal factor data and identified the risk and protective factors for your community, the next step in developing a comprehensive substance abuse plan is to develop a problem statement. The problem statement will guide the selection of the target audience (who you are trying to reach), and will later help you select the best strategies for reaching this audience, as well as the most appropriate domains (or settings) in which to apply these strategies so that there is a clear and consistent message throughout your community.

Who Is Your Target Group?

[9] "Developing Healthy Communities: A Risk and Protective Factor Approach to Preventing Alcohol and Other Drug Abuse," Developmental Research and Program, Inc., 130 Nickerson, Suite 107, Seattle, WA 98109

When designing your prevention plan, keep in mind that different approaches work for different groups. Generally, your target audience will fit one of **three categories**:

- **Universal**

  A universal approach is chosen when you are trying to reach the entire population—e.g., all students in a school, all residents in a community, all parents in a neighborhood. Universal approaches aim to prevent or delay the abuse of alcohol, tobacco, and other drugs among all members of a community or other large group without any prior screening for substance abuse risk.

- **Selected**

  A selected approach is taken if you want to reach specific groups within the general population who are deemed to be at risk for substance abuse by virtue of their membership in a particular population segment—e.g., dropouts, underachieving students, children of alcoholic parents. Risk groups may be identified on the basis of biological, psychological, social, or environmental risk factors known to be associated with substance abuse, and targeted subgroups may be defined by age, gender, family history, place of residence (e.g., low-income neighborhood), victimization by physical or sexual abuse, or membership in a group at risk (e.g. youth experiencing transition, such as fifth or sixth graders moving to middle school or eighth or ninth graders moving to high school). Selective prevention approaches target the entire subgroup regardless of the degree of risk of any individual within the group.

- **Indicated**

  An indicated approach is taken when your target population is just those youth who are at high-risk for alcohol and other drug problems, e.g., youth who are already experimenting with substances or who exhibit other risk behaviors related to substance abuse such as truancy, aggressiveness or violence, or pregnancy. Indicated prevention approaches address risk factors associated with the individual, such as conduct disorder, and alienation from parents, school, and positive peer groups. Less emphasis is placed on assessing or addressing environmental influences, such as community values.

How Do You Choose the Most Effective Strategies for Reaching Your Target Audience?

Risk and protective factors can be changed. The key is to identify priority substance abuse issues and risk and protective factors, determine the realistic and logical outcomes you want to—and can—achieve, and then select the strategies appropriate to achieving these goals. It is essential to have buy-in from the youth whose behavior you are trying to change. The first step in achieving this is to include youth in the coalition and allow them to participate in prevention planning sessions in which decisions are made that will directly affect them.

The strategies a community chooses must also recognize the diversity of the community and the target population (e.g. cultures, ethnicities, religions, ages, genders, socio-economic status) and ensure these groups are a part of the planning process as well.

Six Categories of Strategies

Prior to the widespread adoption of science-based prevention strategies, substance abuse prevention efforts tended to be denoted by six basic categories that defined the nature of the intervention: information dissemination; education; alternative (substance-free) activities; problem identification and referral (early intervention); community-based process; and environmental strategies. These categorizations served as a labeling system only, and are no longer used to determine prevention resource allocations and interventions.

Individual and Environmental Strategies

Individual Strategies: Individually focused strategies focus on the changing the personal attributes of individuals in order to decrease the probability that they will engage in substance abuse. This approach does not include efforts to change the risks that are present in the environment (e.g. availability of alcohol and other drugs, social norms that are permissive of substance abuse).

Environmental Strategies: Environmental strategies involve changing aspects of the environment that contribute to the use of alcohol and other drugs; specifically by limiting access to substances, changing social norms that are permissive of substance abuse; and/or increasing the costs of obtaining substances, in order to decrease the social and health consequences of substance abuse. Environmental strategies establish or change community standards, codes, and attitudes, such as establishing school substance use policies, ensuring consistent enforcement of policies and laws governing alcohol and other drug availability, or modifying alcohol and tobacco advertising practices. The Center for Substance Abuse Prevention has identified seven types of environmental strategies: price interventions; minimum purchase age enforcement; deterrence; location and density of retail outlets; restrictions on use; server-oriented interventions; and counteradvertising. The goal of environmental strategies is to discourage alcohol and other drug use by the general population.

Domains and Settings

As noted previously, the risk and protective factor framework utilizes four key prevention domains: individual/peer, family, school and community. To effect behavior change in youth, the environment in which they live must also change, which means affecting the behavior of the adults and institutions with which they interact. Prevention strategies should therefore be employed in, and through, a variety of

settings within each of the domains. These include: homes; schools; workplaces; health care facilities; media outlets; human services agencies; neighborhoods; parks, youth centers, or other recreational facilities; community organizations; and institutions.

Just as multiple strategies are the most effective way to discourage drug use, so too is providing prevention messages that reinforce one another and are received in the multiple environments of which youth are a part.

What Might a Comprehensive, Community, Research-Based Prevention Plan Include?

Any comprehensive plan should include a combination of proven strategies for each of the four domains of interaction: individual/peer; family; school; and community. Your community should build on existing programs and activities to increase the overall effectiveness of your efforts.

As an example, a comprehensive plan might involve a number of strategies that reach youth, parents, teachers, administrators, service providers, and the general population in schools, via media outlets, through laws and policies, at the doctor's office, or in the neighborhood.

The outcomes your community chooses as part of its plan should be sustainable over time. This requires working through a logic model—conducting a community assessment of needs and resources, identifying risk and protective factors, identifying the target of your initiative, and establishing goals and objectives. In Appendix H, the logic model that forms the foundation of the Evidence-Based Prevention Planning Toolkit is provided. You may wish to refer to this as you work through Phases One and Two of the SICA prevention system and community substance abuse prevention planning processes.

APPENDIX G

CSAP'S CORE MEASURES

ALCOHOL, TOBACCO AND OTHER DRUG USE

- Use (lifetime, monthly)
- Age of first use
- Binge drinking
- Dependency
- Problem Drinking

INDIVIDUAL/PEER DOMAIN

- Perceived harm/risk
- Antisocial attitudes
- Rebelliousness
- Self esteem
- Intention/expectation to use
- Normative beliefs
- Life skills/problem solving
- Leadership/mentoring
- Attitude towards use

FAMILY DOMAIN

- Family composition
- Family history of ATOD use
- Perceived parental attitudes toward youth use
- Family involvement
- Parenting practices
- Family conflict
- Family cohesion
- Parent-child bonding

COMMUNITY DOMAIN

- Neighborhood attachment
- Social disorganization
- Sense of community
- Perceived availability of alcohol and other drugs
- Youth participation opportunities

SCHOOL DOMAIN

- School bonding/commitment
- Academic achievement
- Educational aspirations/expectations
- Parent-school involvement
- School safety/danger

APPENDIX H

SICA PHASE TWO: LOGIC MODEL FOR INITIAL COMMUNITY SUBSTANCE ABUSE PREVENTION PLANNING

IMPORTANT NOTE: THIS LOGIC MODEL ONLY INCLUDES THE FIRST STEPS OF THE PLANNING PROCESS. THE SECOND HALF OF THE LOGIC MODEL, WHICH INCLUDES THE STEPS OF SELECTING STRATEGIES, ACTIVITIES, INDICATORS AND OUTPUTS, WILL BE INCLUDED IN THE FINAL SICA GUIDANCE DOCUMENT, "NEBRASKA PARTNERS IN PREVENTION SICA GUIDANCE DOCUMENT FOR SCIENCE-BASED AND PROMISING SUBSTANCE ABUSE PREVENTION STRATEGIES," WHICH WILL BE RELEASED IN FEBRUARY, 2004.

STEP ONE:	**STEP TWO:**	**STEP THREE:**	**STEP FOUR:**	**STEP FIVE:**
Community needs and resources assessment	Define your target population	Define your goals	Identify objectives	Define measurable outcomes
QUESTION:	**QUESTION:**	**QUESTION:**	**QUESTION:**	**QUESTION:**
What are the major problems you need to address in your community?	Who is most affected by the problem you've identified?	What behavior do you want to change?	What can you do to change the behavior?	How will you know when you've achieved your goal?
ACTION:	**ACTION:**	**ACTION:**	**ACTION:**	**ACTION:**
1. Describe contextual conditions 2. Collect baseline data—demographics, risk and protective factors, incidence and prevalence data 3. Identify existing community substance abuse prevention efforts, possible stakeholders and collaborators for the present effort	1. Develop selection criteria	1. Express the outcome you are trying to achieve—this is your picture of the future. Keep your goals manageable by limiting them to three or fewer	1. Make a direct, logical link between the goals you have defined and the steps you plan to take to reach those goals 2. Make your objectives specific and measurable 3. Focus on decreasing risk factors and increasing protective factors	1. Identify immediate, intermediate, and long-term outcomes 2. Outcomes should be specific, measurable, and time limited

EXAMPLE SICA PHASE TWO LOGIC MODEL FOR INITIAL COMMUNITY SUBSTANCE ABUSE PREVENTION PLANNING

STEP ONE: Community needs and resources assessment	**STEP TWO:** Define your target population	**STEP THREE:** Define your goals	**STEP FOUR:** Identify objectives	**STEP FIVE:** Define measurable outcomes
QUESTION: What are the major problems you need to address in your community?	**QUESTION:** Who is most affected by the problem you've identified?	**QUESTION:** What behavior do you want to change?	**QUESTION:** What can you do to change the behavior?	**QUESTION:** How will you know when you've achieved your goal?
Data collection and analysis for Saline City has revealed that alcohol use is the priority substance abuse issue for youth ages 12-17. Community-specific archival, survey and social indicator data included the following: 1) law enforcement data showed that during recent compliance checks, only 65% of the community's alcohol retail outlets refused to sell alcohol to underage youth, 2) a recent a community survey found that 45% of parents surveyed agreed with the statement that "drinking is a rite of passage for kids, so it's better for them to drink at home," and 3) alcohol is available for sale at all community-sponsored events, including those oriented to families with children.	Youth, ages 12-17 NOTE: this is a "Universal" target population	Decrease alcohol use by youth aged 12 to 17.	1. Increase the number of retail alcohol outlets that refuse to sell alcohol to minor youth aged 12 to 17. 2. Decrease access to alcohol in the home by youth aged 12 to 17. 3. Decrease the availability of alcohol at community-sponsored events	1. By June 30, 2006 the compliance rate for Saline City alcohol retail outlets that refuse to sell alcohol to minors will increase by 33%. 2. By June 30, 2006, the percent of Saline City parents who report attitudes favorable to allowing youth access to alcohol in their homes will decrease by 35%. 3. By June 30, 2006, the number of community-sponsored events in Saline City at which alcohol is available will decrease by 50%.

APPENDIX I

PREVENTION PRINCIPLES[10]

A review of the research has been done to develop principles of effective prevention and intervention. The principles on the following pages represent a preliminary listing based on ongoing work. General principles are presented first, followed by sets of principles organized around the areas of family, school and community. Principles for peers and individuals are encompassed in the first three areas.

When considering these principles, remember:

1. Using more principles does not necessarily result in better programs.
2. Adding principles to a poorly designed or poorly implemented program may improve short-term outcomes, but may still fall short of producing truly effective programs.
3. Program developers must use caution when applying multiple prevention strategies to ensure that the underlying principles complement one another.
4. Other prevention principles not on this list can be identified as long as you can justify the process by which that principle was identified, and can explain the logic of how the principles work together.

General Prevention Principles

1. To be effective, programs should implement a limited number of well-chosen activities. Programs should address a broad range of risk factors.

2. Long-term programs will have a more lasting impact on at-risk groups.

3. Higher levels of risk require more intensive prevention efforts.

4. Prevention programs, to be the most effective, should use culturally appropriate strategies and activities.

5. Programs should use activities that are tailored to the developmental differences among age groups.

6. Prevention strategies applied early in life are likely to be more effective.

7. Prevention efforts aimed at families may be more effective than those directed at children or parents.

8. Prevention programs are most effective when they are designed to reach a specific target population.

9. Beyond changing individual behavior, a comprehensive prevention plan also includes activities aimed at changing the environment.

10. The effectiveness of your program should be evaluated periodically.

11. If adopting an existing prevention program, it should be adapted to address the specific nature of alcohol and other drug abuse in your community.

12. Objectives of community programs should be specific, measurable and time-limited.

[10] Originally listed in the Vermont "New Directions" State Incentive Grant application, as compiled from CSAP's "Science-Based Practices in Substance Abuse Prevention: A Guide; Working Draft, 1998.

Family-Based Prevention Principles

1. It is effective to include sessions in your program where parents and youth learn and practice skills both separately and together.

2. Family-based programs should link families at risk to available counseling services.

3. Family-based programs should reach families at each stage of their development and should match activities to the families' specific needs.

4. Family-based programs should help parents reduce conduct problems and improve parent/child interactions. Skills to be taught could include providing consistent discipline and rules, and monitoring children's activities.

5. Family-based programs should include an educational component for parents that covers specific information about alcohol and other drugs as related to themselves and their children.

6. To make your program accessible to high-risk families, you should consider providing the following: transportation, childcare, incentives for involvement, indigenous trainers, and opportunities for parents to be involved in program changes.

School-Based Prevention Principles

1. School-based programs should reach children at all points from kindergarten to 12th grade. At a minimum, children in their middle school years should be targeted.

2. School-based drug prevention curricula are more effective when teachers receive training and support from program developers or prevention experts. Training may focus on programmatic theory, evaluation, classroom management issues, and use of a particular curriculum.

3. School-based programs should use interactive teaching methods such as modeling and role-playing.

4. School-based programs should impart the societal value of being free from alcohol and other drugs. They should endeavor to give students the skills to resist social pressure, and to be a positive influence on their peers.

5. School-based curricula should begin with a well-tested standardized intervention with detailed lesson plans and student materials.

6. Base your program on factual, up-to-date information, and use as examples realistic situations that reflect students' daily experiences.

7. Some studies have shown alcohol and other drug abuse prevention curricula to be more effective if presented as part of a broader program of health education.

8. School-based programs should foster positive social connections to school and community.

9. Educational interventions for youth that are peer led or include peer-led components are more effective. Peer-led programs tend to require extensive prior instruction for peer educators, however.

Community-Based Prevention Principles

1. Community programs should follow a structured organizational plan, progressing from needs assessment to planning, implementation and review to refinement, w/feedback to/from community at all stages.

2. Community-based programs should be coordinated with other community efforts and components should reinforce each other in theme and content.

3. Community-based prevention programs should be timed to correspond with the readiness of the community or peak community concern.

4. Well-supervised community and recreational activities can reduce alcohol and other drug use and delinquency by providing substance-free activities and increasing monitoring and supervision of children.

5. Substance-free activities should be only one of the strategies included in your comprehensive prevention plan. The combination of substance-free activities, and environmental strategies that reduce the availability of alcohol, tobacco, and other drugs appears to be especially effective.

6. Workplace programs that include drug-free workplace policies can increase community awareness of alcohol and other drug abuse issues.

7. Mentoring programs give youth structured time with adults, and result in reductions in alcohol and other drug use and increases in positive attitude toward others, the future, and school. Participation also results in better school attendance.

Community-Based Prevention—Principles for Coalitions

1. Strong leaders are vital to the success of a coalition. A leader must be able to keep the vision and goals of the coalition alive, and motivate the community to take action.

2. Coalition-based efforts should have a clear purpose, with specific goals and objectives.

3. Membership in a coalition should reflect these goals. There should be a mix of members with different skills and resources, and ordinary citizens in leadership positions.

4. Coalition-based programs should have a plan of cooperation, and clear division of responsibilities amongst coalition members.

5. Coalitions will be more successful if they stay focused on outcomes, and aren't sidetracked by issues of organizational structure.

Community-based Prevention--Principles for Media Campaigns

1. Effective use of the media is primarily demonstrated when the intervention is combined with other prevention strategies (e.g., education, enforcement of existing laws).

2. Delineate the campaign objectives in realistic and measurable terms, specifying the level of change desired (e.g., increased awareness, increased knowledge, change in behavior, change in norms).

3. Specify the target audience as distinctly as possible. As an example, instead of targeting the broad audience of "youth," one might target 5th and 6th grade girls with messages that appeal to that specific group.

4. Decide how you are going to know when your campaign has been successful. Specify the process and outcome measures upon which your campaign will be evaluated.

5. Find out as much as possible about your target group. Review what is known about the target group from past prevention efforts, from adolescent psychology and development, from survey data results (especially from local data). Talk to people who know your target group.

6. Consider conducting "focus groups" or other types of qualitative research to better understand your target group. Survey data is very important, but is no substitute for qualitative research, which give insight into such things as barriers to change or motivations for change.

7. Analyze what factors in the environment of the target group may be working against the efforts of your program, and try to reduce the impact of those "counter forces." For example, what can be done to change mixed messages youth may be getting from their surroundings?

8. Assess which media (e.g., print, radio, transit ads, television) are best suited to the target group as well as the goals of the campaign.

9. Avoid the use of "fear appeals" (trying to scare people away from drugs), negative imagery, and other heavy-handed tactics (like preaching).

10. Have actors model the desired behaviors in all media materials.

11. Avoid modeling drug-using behavior, and avoid showing the drugs themselves. (This includes showing people smoking cigarettes).

12. Provide a context that gives positive reinforcement for the decision NOT to use substances, or negatively reinforces the decision to use (abstainers should have the cool, sexy image). AVOID inadvertently associating positive contexts with drug use (e.g., misguided ads might show drugs being used in a party context with upbeat music and lots of youth looking like they're having fun).

13. Communicate the benefits of staying away from alcohol and other drug use, especially the short-term payoffs (e.g., non-smokers smell better, have whiter teeth).

14. Consider using slightly older "peers" of the target group as spokespersons, rather than celebrities or professional announcers or government officials.

15. Try to use themes that are relevant to the target group. For example, the adolescent theme of wanting social acceptance from peers can be a potent theme that can work in your favor.

16. Consider whether media materials have already been developed that are appropriate for the objectives and target group of your campaign. If so, be sure to pilot test these media materials with members of

your target group.

17. If not, involve members of your target group in the development of media strategies and materials. Pilot test your ideas and message strategies with members of your target group

18. Refine media materials on the basis of pilot testing and then re-test media materials with members of the target group.

19. Minimize the “institutional credits” at the end of your media message so that the focus will remain on the message itself, not on the sponsorship for the message.

20. Have a mechanism for assessing exposure to your media materials among members of the target group.

21. Assess the impact of the media campaign on the target group in terms of the level of change desired. For example, if the campaign goal was to generate behavioral change, have the behaviors changed in the expected direction?

22. Effective use of the mass media to change knowledge, behavior, and attitudes about alcohol and other drugs relies on creating messages that appeal to youth's *motives* for using substances, or *perceptions* of alcohol and other drug use--for example, the perception of risk associated with a particular substance.

23. Effective use of the mass media requires paying for television and radio ads in choice air times, when youth are more likely to be viewing or listening. Public Service ads can enhance any media campaign, but by themselves are unlikely to have an impact on youth if they air at times when few youth are tuning in.

24. Recognize that the interests and TV-watching or radio-listening habits of youth vary depending on age and gender. Design your campaign to allow for the different habits of younger and older adolescents, utilizing radio and television appropriately. Use images and sounds that your target audience can relate to.

Environmental Approaches to Community-based Prevention

1. **Price Interventions.** Increasing the price of alcohol and tobacco through excise taxes is an effective strategy for reducing consumption (both prevalence of use and amount consumed.) It can also reduce various alcohol-related problems, including motor vehicle fatalities, driving while intoxicated, rapes, robberies, cirrhosis mortality, and suicide and cancer death rates. However, efforts to drive up the price of illicit drugs through stricter law enforcement have been relatively ineffective in reducing drug sales.

2. **Minimum Purchase Age Interventions.** Increasing the minimum purchase age for alcohol to age 21 has been effective in decreasing alcohol use among youth (particularly beer), and in reducing alcohol-related traffic crashes. It is associated with reductions in other alcohol-related problems among youth, including suicide, homicide, injuries and vandalism. The effect of minimum purchase age laws for tobacco is not yet known, because such laws have only recently begun to be enforced. Compliance by retailers can be compelled by more frequent enforcement.

   - "Use and lose" laws allow for the suspension of the driver's license of a person under 21 years of age, following a conviction for any alcohol or drug violation (e.g., use, possession, or attempt to purchase with or without false identification). These are an effective means of increasing compliance with minimum purchase age laws among youth. Penalties should be swift, certain, and meaningful. Penalties should not be too harsh, however, since severity is not related to their effectiveness; if too severe, law enforcement and judicial officers may refuse to apply them.

   - Community awareness programs and the media can be effective in increasing the public's perception that impaired drivers are likely to be caught, and can increase retailer compliance. They also help change social norms, making the community less tolerant of sales to, and use by, minors (and decrease the costs of law enforcement.)

3. **Deterrence Interventions.** Deterrence laws and policies for impaired driving have been effective in reducing the number of alcohol-related traffic crashes and fatalities among the general population, and particularly among youth. Reducing the legal BAC limit to .08 or lower in criminal per se laws has been shown to reduce the likelihood of impaired driving.

   - Enforcement of impaired driving laws is important to deterrence because it serves to increase the public's perception that impaired drivers are likely to be caught and punished.

   - Administrative license revocation (which allows a driver's license to be confiscated by the arresting officer if a person is arrested with an illegal BAC or if the driver refuses to be tested) has been shown to reduce the number of fatal traffic crashes and recidivism among DUI offenders. Sanctions that target vehicles and tags by confiscating or conspicuously marking them have mostly been applied to multiple DUI offenders, with some preliminary evidence that they can lead to significant decreases in recidivism and overall impaired driving.

   - Impaired driving policies targeting underage drivers (particularly zero tolerance laws setting BAC limits at .00 to .02 percent for youth and graduated driving privileges, in which a variety of driving restrictions are gradually lifted as the driver gains experience and maturity) have been shown to significantly reduce traffic deaths among young people.

4. **Limiting the location and density of retail outlets.** Limitations on the location and density of retail outlets may help reduce alcohol consumption, and certain other alcohol-related problems, including cirrhosis mortality, suicide, and violence. Neighborhood anti-drug strategies, such as citizen surveillance or civil remedies (particularly nuisance abatement programs) can be effective in dislocating dealers and reducing the number and density of retail drug markets.

5. **Clean Indoor Air laws.** Restrictions on use in public places and private workplaces have been shown to be effective in curtailing cigarette sales and tobacco among both adults and youth.

6. **Employee Training.** Retailer education for tobacco merchants has led to relatively small, short-term reductions in sales to minors. Server-training programs have been found to affect beliefs and knowledge with mixed findings of impacts on server practices and traffic safety measures. When bartender/waiter training is combined with enforcement of laws (against service to intoxicated patrons, against sales to minors), training programs are much more effective in producing changes in selling/serving practices.

7. **Counter-advertising.** Media campaigns about the hazards of a product, or the industry that promotes it, may help reduce cigarette sales. The limited research on alcohol warning labels suggests they may affect awareness, attitudes and intentions regarding drinking, but do not appear to have had a major influence on behavior.

APPENDIX J

GLOSSARY OF TERMS

Assessed Needs: Specific knowledge or skills necessary for achieving or enhancing desired outcomes as identified through data collection and analysis

Coalition: an organized group with strong leadership and multiple partners that has a planning process that is reviewed annually and includes: a community assessment; targeted mission; an action plan with objectives and outcomes; and a process for documentation and feedback.

Community: Administrative or geographic locations defined by legal or administrative boundaries (e.g., counties, cities, school districts, etc.)

Community Readiness: The willingness of a community to implement change strategies that achieve positive outcomes for the health and wellbeing of the community

Cultural Competency[11]: A set of congruent behaviors, attitudes, and policies that come together in a system, agency or among professionals and enable that system, agency or those professions to work effectively in cross-cultural situations. The word "culture" is used because it implies the integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values and institutions of a racial, ethnic, religious or social group. The word "competence" is used because it implies having the capacity to function effectively. Five essential elements contribute to a system's institution's, or agency's ability to become more culturally competent which include:

- Valuing diversity,
- Having the capacity for cultural self-assessment,
- Being conscious of the dynamics inherent when cultures interact,
- Having institutionalized culture knowledge
- Having developed adaptations to service delivery reflecting an understanding of cultural diversity.

These five elements should be manifested at every level of an organization including policy making, administrative, and practice. Further these elements should be reflected in the attitudes, structures, policies and services of the organization.

Evidence-Based: Evidence based planning processes and prevention practices are based upon scientific theory and principles and supported by the collection and analysis of objective data. They have either been (1) formally evaluated, and found to produce desired outcomes in behavior, attitude and/or knowledge, or (2) found to be effective through a formal evaluation that has been published in a peer-reviewed journal.

Environmental Strategies: Environmental strategies involve changing aspects of the environment that contribute to the use of alcohol and other drugs; specifically by limiting access to substances and changing social norms that are permissive of substance abuse in order to decrease the social and health consequences of substance abuse.

Inclusion: Inclusion is the right of all of Nebraska's diverse populations to participate fully and equally in decision-making, policy development, and implementation of programs, policies and practices

[11] From Cross, T., et. al., (1989). Towards A Culturally Competent System of Care Volume I. Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center

Individual Strategies: Individually focused strategies focus on the changing the personal attributes of individuals in order to decrease the probability that they will engage in substance abuse. This approach does not include efforts to change the risks that are present in the environment (e.g. availability of alcohol and other drugs, social norms that are permissive of substance abuse).

Infrastructure: The underlying foundation or basic framework that supports the effective functioning of a community or society in achieving desired outcomes

Logic Model: A sequential series of steps used to conduct an evidence-based strategic planning process that focuses on achieving results rather than just selecting strategies. The elements of a logic model include:

- Mission
- Assessment
- Problem Statement and Target Population
- Goals, Objectives, and Outcomes
- Strategies, Activities, and Outputs
- Indicators
- Evaluation
- Sustainability

Policy: Rules, regulations, standards, or laws designed to prevent the abuse of alcohol, tobacco and other drugs (e.g., 0.08 Blood Alcohol Content laws, keg registration)

Practices: Standard activities that are based on policy and designed to prevent substance abuse (e.g., responsible beverage server training, sobriety checks)

Prevention: The active process of creating conditions and personal attributes that promote the well-being of people

Prevention System: A purposeful, effective and sustained partnership of agencies, organizations and individuals whose missions include substance abuse prevention, that is committed to decreasing substance abuse through a collaborative and coordinated process of:

- Comprehensive planning for—and evaluating—outcomes
- Promoting evidence-based strategies
- Allocating resources
- Workforce development

Program: A structured intervention, including environmental initiatives, that is designed to change social, physical, fiscal, or policy conditions within a definable geographic area or for a defined population. *(Achieving Outcomes, 12/01)*

Promising Strategies: Strategies that are based upon scientific theory and principles that have been implemented, formally evaluated, and found to produce desired outcomes in behavior, attitude and/or knowledge

Science-Based Strategies: Strategies that are based on scientific theory and principles that have been implemented and found to be effective through a formal evaluation that has been published in a peer-reviewed journal

Strategies: Policies, programs, and practices that promote the well-being of people and reduce the consumption of—and the problems associated with—alcohol, tobacco, and other drugs

Subrecipient: An eligible community coalition selected through NePiP ‘s SICA application and review process to receive federal SICA funds

Substance Abuse: Substance abuse encompasses: (1) the illegal use of alcohol, tobacco or other drugs, or (2) any use by minors of alcohol, tobacco or other drugs, including hazardous chemicals such as inhalants

Sustainability: Sustainability is the ability to generate/regenerate efforts that thrive and produce desired outcomes over the long term through effective community infrastructures and processes

Sustainable Processes: Processes that are based on data, open communication, regular review, and adaptation as needed, of mission, resources, needs, strategies and progress, to ensure achievement of desired outcomes

System: A regularly interacting, interdependent and unified network of entities with a shared mission, organized to further its common purpose

Technical Assistance: Site-specific problem solving and other professional assistance based upon assessed needs

Technical Support: Support encompasses technical assistance and all forms of education and skill building, including initiative-specific training and more general organizational development

APPENDIX K

INTERNET RESOURCES FOR SUBSTANCE ABUSE PREVENTION

Center for Faith-Based & Community Initiatives (CFBCI), Department of Labor

www.dol.gov/cfbci

Help with solicitation for grant applications and information on the development of effective community partnerships.

Center for Substance Abuse Prevention (CSAP)

www.samhsa.gov/centers/csap/csap.html

Provides information on effective community prevention.

Community Anti-Drug Coalitions of America (CADCA)

www.cadca.org

CADCA's site features information on starting a coalition, developing community capacity, grant-writing tips, and sources of funding.

Community Toolbox

http://ctb.lsi.ukans.edu/

Models for community development, assessment, organizational structure, strategic planning, and achieving outcomes

CSAP's Centers for the Application of Prevention Technologies (CAPT)

www.captus.org

The fundamental mission of the national CAPT system is to bring research to practice. The system is comprised of six regional Centers (Nebraska is part of the Southwest CAPT) promoting and helping people implement science-based prevention programs and practices.

Join Together

www.jointogether.org

Provides information on community strategies, policy change, and other substance abuse prevention efforts.

Minnesota Institute of Public Health (MIPH) Guide to Internet information related to alcohol, tobacco and marijuana.

http://netbook.miph.org

This guide shows you how you can use the Internet to advance your substance abuse prevention efforts. It offers links to over 700 Web sites on alcohol, tobacco, and other drugs and other prevention resources.

National Clearinghouse for Alcohol and Drug Information

www.health.org

Offers a vast array of information on substance abuse prevention programs and research, including community-based approaches to substance abuse prevention.

National Institute on Drug Abuse

www.nida.nih.gov

NIDA's mission is to lead the nation in bringing the power of science to bear on drug abuse and addiction. This site provides up-to-date information on prevention research.

Nebraska State Incentive Cooperative Agreement

www.nebraskaprevention.gov

Nebraska Prevention is the interagency website for prevention in Nebraska, and serves as the official website of the Nebraska State Incentive Cooperative Agreement.

APPENDIX L

Nebraska Partners in Prevention

State Incentive Cooperative Agreement (SICA)
Cooperative Agreement Advisory Council (C.A.A.C)

Chair:	**Lieutenant Governor David Heineman**
SAMHSA:	**Mary Lou Dent**, Program Officer for Nebraska, Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration
State Government:	**Christine Peterson**, Policy Secretary, NE Health & Human Service System **Steve Curtiss**, Director, Finance and Support, NE Health & Human Service System
State Agency Heads:	**Doug Christensen**, Commissioner, NE Department of Education **Fred Zwonechek**, Administrator, Department of Highway Safety **Allen Curtis**, Executive Director, NE Commission on Criminal Justice and Law Enforcement (Crime Commission) **Michael Heavican**, U.S. Attorney, U. S. Attorney's Office **Edward Birkel**, Probation Administrator, Nebraska Supreme Court **Chris Hanus Schulenberg**, Deputy Administrator, Protection and Safety, NE Health & Human Service System **Romeo Guerra**, Deputy Director, Preventive and Community Health, NE Health & Human Service System **George Hanigan**, Deputy Director, Behavioral Health, NE Health & Human Service System **Ron Sorensen**, Administrator, Office of Mental Health, Substance Abuse & Addiction Services, NE Health and Human Service System
Legislature:	**Senator Jim Jensen**, District 20, Nebraska Legislature **Senator Chip Maxwell**, District 9, Nebraska Legislature **Senator Ray Aguilar**, District 35, Nebraska Legislature
Special Constituencies and At-Large:	**Sally Sylvester**, State Alcohol & Drug Abuse Advisory Council **Dan Hoyt**; Director, Bureau of Sociological Research, University of Nebraska-Lincoln **Kevin Flores**, member, Nebraska Minority Public Health Assn. **Judi Morgan gaiashkibos,** Executive Director, NE Commission on Indian Affairs **Carrie A. Wolfe**, Community Member **Joel Gajardo**, Community Member **Dr. Keith Parker**, University of Nebraska-Lincoln **Frank Peak**, Creighton University **Maria Vu**, Director, Asian Community and Cultural Center **Karen Walklin**, Nebraska Broadcasters Association **Dr. Kenneth Vettel**, Physician, Grand Island **Dr. Jessiline Anderson**, University of Nebraska-Omaha, Clinical Psychologist **Bette Poutre**, Director, Nebraska State Parent Teacher Association **Hon. Justice John Wright**, Nebraska Supreme Court **Jenna Smith**, Youth

NON-VOTING Staff and Consultants

SICA Staff:	**Laurie Barger Sutter**, SICA Project Director/Behavioral Health Prevention Program Manager, Office of Mental Health, Substance Abuse and Addiction Services; NE Health & Human Service System **Julie Mayers**, SICA Grant Manager, Office of Mental Health, Substance Abuse and Addiction Services; NE Health & Human Service System **Faith Mills**, Youth Development Specialist/Consultant, Office of Mental Health, Substance Abuse & Addiction Services; NE Health & Human Service System
SICA Consultants:	
SW CAPT:	**Carl Shackelford,** State Liaison, Southwest Center for the Application of Prevention Technologies (SWCAPT) **Karen Abrams**, Nebraska Liaison, SWCAPT
CSI:	**Patty Martin,** Evaluation Consultant, Community Systems International
PIRE:	**Robert Flewelling**, Senior Research Scientist, Chapel Hill Center, PIRE
JBS:	**Deidra Dain**, Johnson, Bassin and Shaw

APPENDIX M

NEBRASKA PARTNERS IN PREVENTION

Potential Applicant Registration Form

Name of applicant coalition:_____

Contact person:_____

Address: _____

Telephone number:_____ E-mail: _____

Intended Fiscal Agent Organization:_____

Signature of Contact Person:_____

List the key partners and prevention system members within the community that are represented and currently active (regularly attend meetings or participate in program planning) in your coalition. Examples: public and behavioral health members; schools, school districts and ESU's; law enforcement; business community; faith community; media; youth; parents; social services; volunteer organizations:

Define the geographic area covered by your coalition in terms of the town(s), school district(s), tribal reservations, or county(ies) covered.

Please remit this letter to:

Laurie Barger Sutter
SICA Director/Behavioral Health Prevention Program Manager
Nebraska Health and Human Service System
Division of Mental Health, Substance Abuse and Addictions
P.O. Box 98925
Lincoln, NE 68509-8925
402.479.5162 (fax) or laurie.sutter@hhss.state.ne.us

Please contact Laurie Barger Sutter at (402) 479-5573 with any questions.

APPENDIX N

NEBRASKA PARTNERS IN PREVENTION

STATE INCENTIVE COOPERATIVE AGREEMENT APPLICATION COVER SHEET
(Print or type, with exception of signature lines)

APPLICANT ENTITY/ NAME OF PARTNERSHIP: _____

_____

Lead Agency: _____

Lead Agency Contact Person: _____

Title: _____

Address: _____

City_____ZIP Code_____

Telephone Number (_____) _____Fax (_____) _____

Email Address_____

Geographic area of service

_____

Total Amount Request: $_____

This application is complete and accurate to the best of my knowledge. I understand that funding decisions will be made based on the merits of the applications received and the needs of the State.

_____ _____
Signature of Coalition or Partnership Authorized Representative Date

_____
Title (print or type)

I have read the attached application. I acknowledge the commitments implied by this application, and agree to provide the ongoing support and involvement of my office/agency, should this application be funded.

_____
Name of Fiscal Agency and Authorized Agency Official (print or type)

_____ _____
Signature of Fiscal Agency Official Date

_____
Address/Phone Number (print or type)

APPENDIX O

NEBRASKA PARTNERS IN PREVENTION

APPLICATION CHECKLIST

Following is a listing of the materials your application should contain when complete:

1. Application Cover Sheet ____

2. Application Checklist ____

3. Abstract ____

4. Mission Statement ____

5. Coalition Prevention System Plan, including: ____

- Assessment
- Areas of Development (a.k.a. "Problem Statement)
- Goals, Objectives and Outcomes
- Strategies and Activities
- Implementation Plan
- Evaluation

6. Community Substance Abuse Prevention Plan, including: ____

- Assessment
- Problem Statement
- Target Population
- Goals, Objectives and Outcomes
- Strategies and Activities
- Implementation Plan
- Sustainability Plan
- Evaluation Plan ____

7. Management/Staffing Plan ____

8. Budget and Budget Justification ____

9. Statements of Commitment ____

10. Signed Certifications (including an approved Tribal Resolution if applicable) ____

11. Logic Model attachments for 1) Prevention System Planning, and, 2) Community Substance Abuse Prevention Planning ____

APPENDIX P

BUDGET WORK SHEETS

The Budget Work Sheets you will need to complete are contained in this appendix:

- **Project Budget Summary**
- **Project Budget: Revenue and Expenses**
- **Budget Justification**

NEBRASKA PARTNERS IN PREVENTION
PROJECT BUDGET SUMMARY

Enter all budget category totals for "Funds Requested" in the appropriate line items in the "State Incentive Cooperative Agreement" funds column (column B) of the Project Budget Summary. Enter any other project revenue sources from other funding streams in columns C through F on the Project Budget Summary form. Sum up all project cost categories across funding streams and enter totals across the bottom of the table, as well as in column G.

Coalition/Organization:						
Project Title:		**Amount Requested:**		**Project Beginning Date:**		**Project Ending Date:**
A **Cost Categories/Source**	**B** **State Incentive Cooperative Agreement**	**C** **Other Federal Funds**	**D** **Other State Funds**	**E** **Client Fees**	**F** **Other Funding**	**G** **Total Project Budget**
Personal Services						
Operations						
Travel						
Other Expenses						
Totals						

NEBRASKA PARTNERS IN PREVENTION
PROJECT BUDGET: REVENUE AND EXPENSES

Applicants must prepare a detailed project budget using the format below.

A. Personnel Costs

Costs in this category include staff and fringe benefits (e.g. FICA, insurance, retirement). Include position title and salary for each staff person to be paid for through the project. In Column 1, list all positions for which salaries will be paid from this contract. In Column 2, enter the annual (12-month) salary rate for each position that will be filled for all or any part of the year. In Column 3, enter the number of months each position will be filled. In Column 4, enter the percent of time the incumbent will devote to the project during the number of months shown in Column 3. In Columns 5 and 6, enter the expected source of funding.

Personnel Positions (Direct Cost Only) 6/1/04-5/31/05	**Annual Salary Rate**	**No. Mos. Budget**	**% of Time**	**Source of Funds**	
				Applicant and Other (Identify)	**Requested from SICA**
% of Fringe					
Category Subtotal	$			$	$

B. Operating Expenses

Costs in this category include: postage, printing, copying, utilities, office supplies, repair and maintenance costs. Identify the subject of the funding in Column 1. Show the expected source of the funding for this amount in Columns 2 and 3.

Operating Expenses by Category (Direct Cost Only) 6/1/04-5/31/05	**Source of Funds**	
	Applicant and Other (Identify)	**Requested from SICA**
Category Subtotal	$	$

C. Travel

Estimate total travel costs associated with the project (e.g. lodging, meals, mileage, etc). Budget should include travel expenses to attend quarterly meetings in Lincoln, as well as an annual conference in Lincoln.

Itemized Travel Expenses (Direct Cost Only) 6/1/04-5/31/05	**Number of Days/Miles**	**Rate of Reimbursement**	**Source of Funds**	
			Applicant and Other (Identify)	**Requested from SICA**
Category Total		$	$	$

D. Other Expenses

Please include other costs that may not be included in the above categories, and explain their relationship to the project (e.g. rental of facilities, supplies, materials, training, etc).

Other Expenses 6/1/04-5/31/05	**Source of Funds**	
	Applicant and Other (Identify)	**Requested from SICA**
Category Total	$	$

BUDGET JUSTIFICATION

I. Provide supportive description and justification for each budgeted line item.

A. Personal Services

B. Operations

C. Travel

D. Other Expenses

II. Documentation of Science-Based and Promising Strategies

Document that at least 50% of budget is allocated to science-based strategies, with the remainder allocated to "promising" strategies as defined in the Guidance Materials.

III. Ability to Leverage Resources

Describe the applicant's ability to leverage structural and financial resources at the community and private sector levels.

IV. Financial Management

Describe the ability of the applicant's fiscal agent to track, manage, and administer federal funds.

V. Sustainability

Describe plans for developing and sustaining the local prevention system, as well as for sustaining the project's outcomes beyond the grant period.

APPENDIX Q

NEBRASKA PARTNERS IN PREVENTION

SUBRECIPIENT CERTIFICATIONS

Certification Regarding Lobbying

The undersigned certifies, to the best of his or her knowledge and belief that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency. A Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, Disclosure Form to Report Lobbying in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was place when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

_____ _____

Signature of authorized official signing on behalf of applicant organization — Date

_____

Name and title of official signing for organization

_____

Organization name

Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable Federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing this certification, the applicant/subgrantee certifies that the submitting organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

_____ _____

Signature of authorized official signing on Behalf of applicant/subgrantee

Date

_____

Name and title of official signing for organization

_____

Organization name

APPENDIX R

NEBRASKA PARTNERS IN PREVENTION

SubGrant Terms and Assurance

This is a subgrant of federal financial assistance. By accepting this subgrant, the Subrecipient agrees to comply with the terms and conditions described herein.

A. Programs. Subrecipient must operate the program(s) in compliance with the documents governing the award. The following documents and any revisions made during the program period govern the Subgrant and are hereby incorporated by this reference as though fully set forth herein.

1). The State's Request for Application;
2). The Subrecipient Project(s) Application;
3). The Subrecipient Reporting Requirements;
4). Program Specific Requirements;
5). Certifications (Appendix Q); and
6). State funding award that includes the award period, amount of funds awarded, and any contingencies to the Subgrant award.

B. Reports. Subrecipient must submit data, program, and financial reports according to the reporting requirements. Extensions for the submission of reports and reimbursement **must be submitted in writing** to the State for approval to prevent withholding of payment.

C. Administrative Requirements. Subrecipient must perform Subgrant activities, expend funds, and report financial and program activities in accordance with Federal grants administration regulations and U.S. Office of Management and Budget Circulars governing cost principles, and comply with, complete, and return the certifications attached hereto.

D. Program Specific Requirements. Subgrant activities must comply with any program specific requirements included in the Department's Request for Application.

E. Nondiscrimination. The Subrecipient acknowledges that the Subgrant activities must be operated in compliance with civil rights laws and any implementing regulations, and makes the following assurances.

1). The Subrecipient warrants and assures that it complies as applicable with:
   a) Title VI of the Civil Rights Act of 1964,
   b) Title IX of the Education Amendments of 1972,
   c) Section 504 of the Rehabilitation Act of 1973,
   d) the Age Discrimination Act of 1975,
   e) the Americans with Disabilities Act of 1990, to the effect that no person shall, on the grounds of race, color, national origin, sex, age, handicap or disability, be excluded from participation in, denied benefits of, or otherwise be subjected to discrimination under any program or activity for which the Subrecipient receives federal financial assistance.

2). The Subrecipient and any of its subcontractors shall not discriminate against any employee or applicant for employment, to be employed in the performance of this Subgrant with respect to hire, tenure, terms, conditions or privileges of employment because of the race, color, religion, sex, disability or national origin of the employee or applicant.

F. Reimbursement: Subrecipient must submit claims for reimbursement for actual, allowable, allocable and reasonable expenditures in accordance with the approved budget. The State will make reimbursement, subject to the following conditions:

1). Subrecipient's submission of reports according to the reporting requirements

2). Availability of governmental funds to support this project. In the event funds cease to be available, this Subgrant shall be terminated, or the activities shall be suspended until such funds become available, in the sole discretion of the State.
3). Pursuant to the Nebraska Prompt Payment Act.
4). Suspension or termination for cause or convenience as described in the federal grants administration regulations applicable to the Subrecipient.

G. Budget Changes. The Subrecipient is permitted to reassign funds from one line item to another line item within the approved budget. Prior approval by the State is not required provided the cumulative transfers do not exceed ten percent of the total approved budget, are for an allowable cost allocable to the Subgrant, do not add or eliminate a line item, do not result in programmatic changes, and do not shift the balance of funding allocated for science-based prevention strategies to below 50% of total funding.

Prior approval is required for cumulative budget transfers exceeding ten percent of the current total approved budget. Requests for transfers shall be addressed in writing to the State. The State shall approve or disapprove the request in writing within 30 days of its receipt.

H. Programmatic changes. The Subrecipient shall request in writing State approval for programmatic changes. The State shall send a written determination regarding the request to the Subrecipient within 30 days of its receipt.

I. Technical Assistance. The State will provide training and materials, procedures, assistance with quality assurance procedures, and site visits by representatives of the State and the federal granting agency in order to review program accomplishments, evaluate management control systems and other technical assistance as needed or requested.

J. Subrecipient Procurement. Subrecipient shall be the responsible authority regarding the settlement and satisfaction of all contractual and administrative issues, without recourse to State, arising out of procurement entered into by it in connection with the subgrant. Such issues include, but are not limited to, disputes, claims, protests of award, source evaluation and other matters of a contractual nature.

K. Subgrant Close-Out. Upon the expiration or notice of termination of this Subgrant, the following procedures shall apply for dose-out of the subgrant:

1). Upon request from Subrecipient, any allowable reimbursable cost not covered by previous payments shall be paid by State.

2). Subrecipient shall make no further disbursement of funds paid to Subrecipient, except to meet expenses incurred on or prior to the termination or expiration date, and shall cancel as many outstanding obligations as possible. State shall give full credit to Subrecipient for the federal share of non-cancelable obligations properly incurred by Subrecipient prior to termination.

3). Subrecipient shall immediately return to State any unobligated balance of cash advanced or shall manage such balance in accordance with State instructions.

4). Within a maximum of 30 days following the date of expiration or termination, Subrecipient shall submit all financial, performance and related reports required by the terms of the Agreement to State. State reserves the right to extend the due date for any report and may waive, in writing, any report it considers to be unnecessary.

5). State shall make any necessary adjustments upward or downward in the federal share of costs.

6). The Subrecipient shall assist and cooperate in the orderly transition and transfer of subgrant activities and operations with the objective of preventing disruption of services.

7). Close-out of this Subgrant shall not affect the retention period for, or state or federal rights of access to, Subrecipient records. Nor shall close-out of this Subgrant affect the Subrecipient's responsibilities regarding property or with respect to any program income for which Subrecipient is still accountable under this Subgrant. If no final audit is concluded prior to close-out, the State reserves the right to

disallow and recover an appropriate amount after fully considering any recommended disallowances resulting from an audit which may be conducted at a later time.

L. Documents Incorporated by Reference. All laws, rules, regulations, guidelines, directives and documents, attachments, appendices, and exhibits referred to in these terms and assurances shall be deemed incorporated by this reference and made a part of this Subgrant as thought fully set forth herein.

M. Independent Contractor. The Subrecipient is an independent contractor and neither it nor any' of its employees shall be deemed employees of the State for any purpose. The Contractor shall employ and direct such personnel as it requires to perform its obligations under this Subgrant, shall exercise full authority over its personnel, and shall comply with all worker's compensation, employer's liability, and other federal, state, county, and municipal laws, ordinances, rules, and regulations required of an employer providing services as contemplated by this Subgrant.

N. Release and Indemnity. The Subrecipient shall assume all risk of loss and hold the State, its employees, agents, assignees and legal representatives harmless from all liabilities, demands, claims. suits, losses, damages, causes of action, fines or judgments and all expenses incident thereto, for injuries to persons and for loss of, damage to, or destruction of property arising out of or in connection with this Subgrant, and proximately caused by the negligent or intentional acts or omissions of the Subrecipient, its officers, employees or agents; for any losses caused by failure by the Subrecipient to comply with terms and conditions of the Subgrant; and, for any losses caused by other parties which have entered into agreements with the Subrecipient.

O. Drug-Free Work-Place Policy. The Subrecipient assures the State that it has established and does maintain a drug-free work-place policy.

P. Acknowledgment of Support. Publications by the Subrecipient, including news releases and articles, shall acknowledge the financial support of the State and the federal granting agency by including a statement therein that, **"This project is supported by federal State Incentive Cooperative Agreement funds awarded to the Subrecipient by Nebraska Partners in Prevention on behalf of the Nebraska Governor's Office and the Substance Abuse and Mental Health Services Administration."**

Q. Copyright. The Subrecipient may copyright any work that is subject to copyright and was developed, or for which ownership was purchased, under an award. The federal awarding agency and the State reserve a royalty-free, nonexclusive and irrevocable right to reproduce, publish, or otherwise use the work for Federal and State purposes, and to authorize others to do so.

R. Notices. All notices given under the terms of this Subgrant shall be sent by United States mail, postage prepaid, addressed to the respective party at the address set forth on the signature page hereof, or to such other addresses as the parties shall designate in writing from time to time.

S. Authorized Official. The person executing the Application Cover Sheet is an official of the Subrecipient who has the authority to bind the Subrecipient to the terms and assurances of this Subgrant of federal financial assistance.